

TURNING POINT COUNSELING
19250 Everett Lane, Suite 103, Mokena, IL 60448

CLIENT NAME (as listed with insurance): _____

Preferred Name or Nickname: _____ **MARITAL STATUS:** _____

DATE OF BIRTH: _____ **GENDER** (as listed with insurance): Female Male

PHONE: _____ Mobile Home Work **Ok to call?** _____ **Voicemail?** _____

PHONE: _____ Mobile Home Work **Ok to call?** _____ **Voicemail?** _____

Is TEXTING a comfortable form of communication and do you give consent? Yes No

Do you give consent to receive EMAIL correspondence or statements? Yes No

E-MAIL ADDRESS: _____

BILLING ADDRESS: _____

City: _____ State: _____ Zip Code: _____

EMPLOYER NAME: _____ **CITY:** _____

IF MINOR (UNDER 18), NAME OF LEGAL GUARDIAN: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

Relationship: _____

Referral Source? Friend/Family Psychology Today Insurance Co. TPC Website Other: _____

PRIMARY INSURANCE

INSURANCE CARRIER: _____

PHONE NUMBER: _____

MEMBER ID NUMBER: _____ **GROUP NUMBER:** _____

SUBSCRIBER NAME: _____

RELATIONSHIP TO CLIENT: _____ **ADDRESS SAME AS CLIENT?** _____

SUBSCRIBER DATE OF BIRTH: _____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

I give permission to Turning Point Counseling staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as co-pays, deductibles, and non-covered services. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

SIGNED: _____ **DATE:** _____