VALIDATION RESILIENCE PEACE

HOPE TRUTH EMPOWERMENT FAITH SAFETY

FOUNDATION

FOR HEALING, LLC

"Building Recovery From the Ground Up"

CLIENT INFORMATION SHEET

Client Name on Insurance Card:_______________________________________

Preferred Name: ____

Birth Date: ______ /______ /______ Age: ________ Gender(Expression): ______________

Insurance Company: ____

Member ID: _________________________ Group # ____________________________

Type of Service: (EAP)_________ Regular Behavioral Health Counseling ______________

Other (Explain): ____

EAP Authorization Code: ____

Number of Sessions Allowed Per Year: (EAP) ___________ Regular Services ___________

In-Network Deductible Remaining for the Year: ________ Co-Pay per Session: _________

Out-of-Network Costs: (Deductible) _________________ Co-Pay per Session: _________

Home Address: (Street)____

(City) _________________________________ (State) ______ (Zip code) _____________

Preferred Phone Number: _________________________Cell _________ Home ________

May we Leave Messages on This Number? (Yes) ____ (No) ____ Text? (Yes) ___ (No) ____

Preferred E-Mail? ____

May we Correspond Through E-mail? (Yes) ____ (No) ____ Fax? (Yes) ____ (No) _______

Emergency Contact: ______________________________ Relationship: _______________

Primary Phone Number: _______________________ Secondary: ____________________

Current Medications: ____

Prescriber: __________________________________ Phone: _______________________

Allergies/Illness/Disabilities:____

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