

Alliance Counseling and Education Center

Client Demographic Form

Please fill this form out completely. You are responsible for providing updates if any information changes.

Today's Date: _____

Therapist: _____

CLIENT INFORMATION

Full Name: _____ Marital Status: _____

Is this your legal name? Yes No If not, what is your legal name? _____

Date of Birth: _____ Age: _____ Sex: Male Female

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Driver's License Number: _____

Occupation: _____ Employer: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ Referred to Provider by: _____

LEGAL INVOLVEMENT

If you are currently involved in a child custody dispute, please complete the following.

Your Attorney's Name: _____ Legal Assistant: _____

Address: _____

Street	City	State	Zip Code
Telephone Number: _____		Fax Number: _____	

Is there an Ad Litem or Ambicus Attorney assigned? Yes No If yes, who? _____

Address: _____

Street	City	State	Zip Code
Telephone Number: _____		Fax Number: _____	

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Client Demographic Form Continued

CONTACT AUTHORIZATION

What number can we leave a message on? Home Cell

Can we email you? Yes No

Can we leave a message with a spouse? Yes No

If yes, spouse's name: _____

By providing the information listed above, I authorize ACEC to contact me through the approved methods listed above. I reserve the right to revoke this consent by providing ACEC written notice.

Signature: _____

Date: _____

SERVICE YOU ARE SEEKING

Individual Counseling Couples Counseling Family Counseling

GUARANTOR'S INFORMATION

Guarantor's Name: _____

Date of Birth: _____ Sex: _____

SSN#: _____

Address: _____

Home Phone: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Relationship to Patient: _____

Guarantor's Employer: _____

Employer's address: _____

Employer's Phone: _____

City: _____ State: _____ Zip: _____

IN CASE OF EMERGENCY

Whom may we contact in the event of an emergency? (Please list a local family member or friend not living at the same address).

NAME	RELATIONSHIP	HOME PHONE	WORK/CELL PHONE

PRIMARY INSURANCE

Insurance Name: _____ Behavioral Health Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____

Effective Date: _____

Please complete if subscriber's information is different from the guarantor's information:

Subscriber's Name: _____ SSN#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to patient: _____

SECONDARY INSURANCE

Insurance Name: _____ Behavioral Health Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____

Effective Date: _____

Please complete if subscriber's information is different from the guarantor's information:

Subscriber's Name: _____ SSN#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to patient: _____

PLEASE READ THE INFORMATION BELOW THOUROUGHLY

I consent to ACEC beginning treatment. I understand that to meet my counseling goals it is best to follow therapeutic suggestions. I also understand that I have the right to discontinue counseling or refuse treatment at any time. I understand that I am responsible for any balance due prior to my decision to discontinue treatment.

Client/Guardian Signature

Date