Charleston Clinical Counseling
Client Information Form

Client's Full Name: _____ SS#: _____-____-_____

Address: _____
street city, state, zip

Phone: _____ E-mail address: _____

Sex: M F Age: _____ Date of Birth: _____ Marital Status: _____

Emergency Contact Person: _____

Relationship to Client: _____ Emergency Contact Phone:_____

How did you hear about Charleston Clinical Counseling? _____

By signing below, I authorize use of this form on all my insurance submissions. I authorize the release of information to my insurance company(s). I understand that I am responsible for the full amount of my bill for services provided. I understand payment is due when services are rendered.

_____ _____
Client/Legal Guardian Signature Today's Date

Credit Card #: _____
Expiration Date: _____/_____
Security Code: _____
Billing Zip Code: _____

* The billing information above will only be used in the event that the cancellation policy is broken. Cancellations without 24 hour notice will acquire a $30 cancellation fee, except in the case of an emergency. Please reference the "Appointments/Fee Schedule" section of the Professional Disclosure Statement.