Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Email: Permission to email: Yes No	Birth date:	Age:	Sex: ☐ M ☐ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Medication list:		

How did you find out about this counseling practice?

Reasons for seeking services:

INSURANCE INFORMATION

(Please bring a copy of your ID and Insurance card to your first appointment)

Person responsible for bill:	Birth date:	Address (if different):	Contact Number.:
Have you contacted your insurance to make sure treatment is covered?	☒ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
What is your deductible?	Have you met your entire deductible?	If not how much remaining do you have to pay toward your deductible?	Your deductible must be met before your insurance will kick in.

Please indicate primary insurance: **Subscriber ID:**

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	**Group no.:**	**Policy no.:**	**Co-payment:**

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Emergency Contact Person:	Relationship to patient:	Home phone:	Cell phone no:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Samaria M Colbert. I understand that I am financially responsible for any balance. I also authorize Kingdom Creative Counseling PLLC or Samaria M Colbert to release any information required to process my claims.

Patient/Guardian signature Date