SUMMIT COUNSELING

Sarah West-Effland LCSW, LLC, Owner of Summit Counseling
618 SE 4th Street, Suite 104, Lee's Summit, MO 64063
Telephone: (816) 282-2161 / Fax: (816) 396-8380

New Client Information

Client's Information

*Legal Name: Nickname:
First MI Last

*Home Address:

*Street:

*City: *State: *Zip:

*E-mail Address:

Home Phone #:

Business Phone #:

*Main Cell Phone #:

Other Important Phone #: Type of Phone #:

*Date of Birth:

*Gender (as listed with Health Insurer): Female Male

*Marital Status (choose one): Single Married Other (Divorced, Widowed, & Domestic Partnerships)

*School or Work Status: F/T Student P/T Student OR Employed Not Employed

Family Information

*Spouse's Name: Age:
First MI Last

Spouse's Employer:

Spouse's Business Phone #:

*Children/Siblings *(First Names & Ages Only)*:

*Other Extended Family Members Living with the Client:

Name: Relationship to Client:

Name: Relationship to Client:

*(All areas marked with a * MUST be completed)*

Primary Insurance Information

*Insurance Company Name:

Insurance Company Phone #:

*Subscriber's Name *(if different)*:

*Subscriber's Date of Birth: *Relationship to Client:

*Subscriber's Employer:

*Subscriber's Insurance ID#:

*Subscriber's Group Policy/ID #:

*Subscriber's Phone # *(if different)*:

*Subscriber's Address *(if different)*:

*Street:

*City: *State: *Zip:

Secondary Insurance Information

*Insurance Company Name:

Insurance Company Phone #:

*Subscriber's Name *(if different)*:

*Subscriber's Date of Birth: *Relationship to Client:

*Subscriber's Employer:

*Subscriber's Insurance ID#:

*Subscriber's Group Policy/ID #:

*Subscriber's Phone # *(if different)*:

*Subscriber's Address *(if different)*:

*Street:

*City: *State: *Zip:

Emergency Contact Information

*Contact Name: *Relationship to Client:

*Contact Phone #1:

*Contact Phone #2:

*Contact's Address *(if different)*:

*Street:

*City: *State: *Zip:

Mental Health Information

* Reason(s) for seeking counseling *(check all that apply)*:

Abuse/ Trauma	Chronic Pain	Family	Phobias
ADD/ADHD	Compulsions	Grief/Bereavement	Self Harm
Anger	Couple/Marital	Medically Related	Sexuality
Anxiety	Depression	Obsessions	Stress
Children	Employment	Panic Attacks	Substance Abuse

Other Issues *(please specify)*:

*How long ago did the Client first experience the issue(s) they are seeking counseling for?

*Periods of prior counseling and/or psychiatric hospitalizations *(if applicable)*:

*Prescribed Mental Health Medications *(Name, Dosage, and Frequency)*:

Physical Health Information

*Does the Client have a Primary Care Physician *(choose one)*? Yes No

*Primary Care Physician's Name:

*Primary Care Physician's Phone #:

*Is the Client currently experiencing any chronic physical issues or limitations *(choose one)*? Yes No

Briefly explain any physical issues:

*Does the Client smoke or use tobacco produces *(choose one)*? Yes No How often?

*Does the Client drink alcohol regularly *(choose one)*? Yes No How often?

*Prescribed Physical Health Medications *(Name, Dosage, and Frequency)*:

*(All areas marked with a * MUST be completed)*

Involvement in Care Information

The following are allowed access to my treatment as specified below.

Name/Phone #	Type of Information

Automated Contact Information

I consent to receiving e-mails regarding appointments and billing *(choose one)*: Yes No

Preferred e-mail address:

I consent to receiving SMS/texts regarding appointments and billing *(choose one)*: Yes No

Preferred text #:

Notice of Privacy Policies

I hereby acknowledge that I have reviewed the Notice of Privacy Practices for Summit Counseling.

*Client *(or guardian)* signature: Date:

*I hereby certify that the Client listed in this document has active behavioral health coverage with the Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to Sarah West-Effland LCSW, LLC.

I further understand that if the Client's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the Client's insurance policy. I hereby authorize the Practice to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.

*Client *(or guardian)* signature: Date:

For filling out this form electronically:
Just type your name into the signature field(s) above to sign the form.