Agape Empowerment Counseling Services, LLC 1111 E. 54h Street , Suite 115, Indianapolis, IN 46220 317- 543-9769

New Client Information Form

Please print legibly and sign your name where indicated

General Information

Name _____ Birth Date _____ SS# _____

Address/City/Zip _____

Phone-Home _____ Work _____ Cell _____

Email_____

Problems of concern_____

Suicidal thoughts or attempts in last month? yes or no Hallucinations: yes or no If yes, please explain_____

Can we send you our monthly e-newsletter? YES, thanks NO, thanks (please circle)

How should I identify myself if I need to contact you? _____

(If there is/are any limitations on me calling you, please note them here) _____

_____

Insurance Information

Insurance Co. _____ ID# _____ Group# _____

Co-Pay_____ Deductible_____ Precert Required Yes or No

Insured's Name _____ Insured's SS# _____ Relationship to you _____

Secondary Insurance Co./ ID# _____

I authorize my counselor, Arlinda D. Lindsay, to release information needed to obtain mental health insurance benefits. I understand that I can rescind this authorization at my request, and in writing, should I make other arrangements for payment of services rendered.

Signed _____ ***Date*** _____

Miscellaneous Information

Emergency Contact Person _____Phone _____

Referred by Whom _____ Presenting Concern _____

Primary Physician to be contacted in case of emergency _____ Phone _____

I have read and understand the above information

Signed _____ ***Date*** _____

Indiana Notice Form

I am required to provide you with the attached Notice of Policies & Practices to protect the privacy of your health information. Please keep this for your records. As required by Federal Law (HIPAA), please sign to indicate that you've received the IN Notice Form. ***Signed*** _____ ***Date*** _____