

LIGHTING A NEW WAY COUNSELING SERVICES
1500 S Sycamore Ave, Ste 102
Sioux Falls, SD 57110
(605) 361-0114

For office use only: CL _____ DX _____ MCP _____
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(Please Print)

CLIENT INFORMATION

Date _____ Social Security # _____ - _____ - _____

Name _____
(Last) (First) (Middle) (Other/Maiden)

Address _____
(Street) (City) (State) (Zip Code)

County _____ Date of Birth ____/____/____ Age _____ Gender: Male Female

Home Phone (____) _____ Work Phone (____) _____
OK to leave message? Yes or No OK to leave message? Yes or No

Civil Status: Single Married Divorced Widowed Separated

Race: Asian Black Caucasian Hispanic Native American Other

SPOUSE/PARENT (If the client is a minor):

Name: _____ Custody held by: _____

Address (if different from your child): _____

GUARANTOR INFORMATION

Please provide information regarding person(s) responsible for payment of amounts not covered by insurance. Be prepared to supply your insurance card(s) at time of first visit so that a photocopy can be taken. Thank you.

Bill to Parent(s)/Guardian(s) (if client is a minor): _____

Address (if different from client): _____
(Street) (City) (State) (Zip Code)

Name of Insurance Policy Holder: _____ Relationship to client: _____
(as it appears on insurance card) Self Spouse Parent/Guardian

Policy Holder's Employer: _____ DOB: _____ SS# _____

PRIMARY INSURANCE:

Insurance Company: _____ ID# _____ Group # _____

Is pre-authorization required? Yes No Not sure What is your deductible? _____

Do you have a co-pay? Yes No Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? Yes No Not sure

SECONDARY INSURANCE:

Insurance Company: _____ ID# _____ Group # _____

Is pre-authorization required? Yes No Not sure What is your deductible? _____

Do you have a co-pay? Yes No Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? Yes No Not sure

LIGHTING A NEW WAY COUNSELING SERVICES, IN ASSOCIATION WITH



NAME & RELATIONSHIP OF FAMILY MEMBERS:

EDUCATIONAL HISTORY OF CLIENT:

School Attended/Attending _____ Graduation Date _____

University/Tech School _____ Graduation Date _____

HEALTH INFORMATION:

Referral Source: _____ Religious Preference (optional): _____

Have you had any previous mental health treatment elsewhere? Yes No

If yes, where and with whom? _____

List any significant health concerns: _____

Do you smoke? Yes No Packs per day? _____ For how long? _____

Do you use alcoholic beverages? Yes - If yes, how often? _____ No

Do you use illegal drugs or substances? Yes - If yes, how often? _____ No

Are you currently under the care of a physician? Yes No

Physician: _____ Phone: _____

Please list medications you are currently taking:

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

PHYSICIAN AUTHORIZATION

If your physician referred you, it is often useful for your therapist to confer with him/her regarding your diagnosis and treatment.

I give my permission for my therapist, _____, to release records and/or information about my treatment to my personal physician for the purpose of treatment, planning and coordinating psychotherapy with my health care needs. I may withdraw this consent at anytime in writing or verbally, by advising my therapist named above.

Yes, I AUTHORIZE this release.

NO, I DO NOT.

I hereby authorize my therapist to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process claims. In addition, I hereby authorize direct payment of medical benefits to my therapist for services rendered.

Signed: _____ Date _____

(Client – Parent – Guardian)