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______________________________

(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

Preferred Phone (____) _______________________ Email Address ______________________________
*Is this a mobile phone? 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

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)