

PROSPECTIVE CLIENT DATA FORM

WELCOME!! Please share with us the following information. We can then help you determine if it would be a good fit to work with Dr. Warner. If you have any questions you can contact us at: (678)775-6704. **You have choice in how you send us this form. You can complete it online and then email it back to us or, you can download the form and fax it to (678) 954-6616 or, mail it to: Breakthru Counseling & Consulting, P.C., 6340 Sugarloaf Parkway, Ste. 200, Duluth, Georgia, 30097.** Also, we need to alert you if you choose below to communicate with us by electronic transmission (texts, cell phone, faxes and/or emails) you assume the risk this may pose to client confidentiality. In this day and age of hackers, there is no 100% guarantee of confidentiality for any of us via electronic transmission. Thus, privacy of electronic transmissions cannot be assured. However, we'll do our utmost to preserve your confidentiality on our end. Upon receipt and review of your information, we'll contact you to discuss setting up an appointment. Please make sure you give us a day and night time phone number. We look forward to serving you!

Information on person filling out this form:

Name: _____ Home phone: _____ Work phone: _____
Cell phone: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
OK to leave a voicemail at? Home: _____ Work: _____ Cell: _____ Email ok to send? _____
Who referred you to BreakThru? _____
What is your relationship to the prospective Breakthru client? _____

Prospective Client Information: *PLEASE PRINT CLEARLY*

DATE: _____

Prospective Client's Name: _____ Date of Birth: _____
Email: _____
Home phone: _____ Cell phone: _____ Work phone: _____
OK to leave a voicemail at? Home: _____ Work: _____ Cell: _____ Email ok to send? _____
Spouse: _____ Spouse's Work phone: _____
Parent (If minor) _____ Work phone: _____ Home: _____
Client's Sex: __ M __ F Age: _____ Marital Status: __ M __ Sin. __ Div. __ Sep. __ Wid.
Client's Race _____ Client's Ethnicity/Culture _____
Is client a U.S. Citizen: __ Y __ N If No, Explain status: _____

Prior Counseling: _____

Type of Counseling sought? For myself ___ Marital ___ For My Child ___ Premarital ___ Other _____
Description of reason client(s) seek counseling: _____

Will you be planning to pay through your insurance? _____ If so, please give us the information requested below, and, as a courtesy service, we'll verify coverage before your appointment and let you know your benefits. If you plan to pay without using insurance, please go now to the "3rd Party" or "SELF PAY" section below, whichever applies. If you want to use your EAP program for payment, please complete the "Insurance/EAP" Section. You'll then need to provide the requested info. for BOTH your EAP & your major medical insurance,

INSURANCE/ EAP INFORMATION:

Do you want to use: Insurance___? EAP___? BOTH___?

If you want to use both EAP and your major medical insurance and they are managed by 2 different insurance companies, *please complete this form and return for each of the different insurance/EAP products you have.* Do you have any secondary insurance? _____. If so, please complete this form and return for **each** insurance company you plan to use in your payment.

Name of the family member the insurance is under (Insured): _____

Insured's Member ID # _____ Insured's Employer _____

Insurance Company Name: _____ Date of Birth of Prospective Client: _____

Some insurance companies will give a separate phone # on their cards labeled: "Mental Health /Alcohol and Substance Abuse phone #". Please give us that # if your card has one: _____

Customer Service Phone #: _____ Provider Phone # _____

Prospective Client's Insurance Information (If different from above)

Prospective Client's Name: _____ Client's DOB: _____

Prospective Client's Member ID # _____

Relation to Insured: _____

Fees: The cost of the initial session will be \$200.00 and following sessions will cost \$175.00 per 45 minute session. Please be advised that any deductible and/or co- payment will be due at each session. *Payment accepted is cash and/or check only. No credit, debit or medical spending cards accepted.* As a courtesy to you we will file your insurance claim for you. **However, the client, not the insurance company, is ultimately responsible for full payment of all fees owed.**

Other 3rd Party Information: If someone other than an insurance company or the client has agreed to pay for the client's counseling, give us all contact information necessary to verify and bill for payment please.

SELF PAY:

If you plan to not use insurance or other third party payers, please be advised that the cost of the first session will be \$200.00 and that following sessions will be charged \$175.00 per forty- five minute session. Payment is due at each session. *Payment forms accepted are cash or check. Credit, debit and/or medical spending account cards are not accepted.*

OFFICE USE ONLY: Download By: _____ Download Date _____ Date to Insur. Clerk _____

Sent to Insur. By: _____ Date Appt. made _____ Appt. Day, Date & Time _____

Client will download intake forms _____ Client will come early _____ Financial policy covered _____ Directions given _____

Business day Cx policy _____ Custodial Parent Permission _____ Notes: _____

Insurance Staff Data Collected: Spoke To: _____ Deductible? _____ Amt. Met? _____

Copy? _____ Max Sess #? _____ Precert Required? _____ 90791 approved? _____ 90847? _____ 90846? _____ 90837? _____

Precert # _____ Total # of Sessions? _____ Client notified _____

Comments: _____