essexcounselingcenter LLC

Date _____

Name _____
First Middle Last

Address _____
Street City State, Zip

Date of Birth _____ Age _____ Marital Status _____

Religion _____ Ethnicity _____ Male ☐ Female ☐

Phone Number _____ May I leave a voicemail? YES ☐ NO ☐

Secondary Number _____ May I leave a voicemail? YES ☐ NO ☐

Email Address – if permitted _____

Occupation/Employer/School _____
Name Location

Emergency Contact _____
Relationship Name Phone Number

What brings you to therapy today? _____

Referral Source? Where did you find us? _____

Medications? Medical concerns? _____

**Required Insurance Billing Information/Authorization to Submit**

Insurance Carrier _____
ID# Group#

Insurance Address _____

Behavioral Health Provider Phone Number – on back of card _____

Policy Holder _____
Name Relation to Client Date of Birth

PreAuthorization # - if applicable _____ Deductible Amount/met? _____

Secondary Insurance – if applicable _____
ID# Group#

Insurance Address _____

# of Allowed Visits _____ Copay? _____ In/Out Network? _____

Signature of Client/Policyholder _____ Date _____

*__OR__ Initial here __only__ if _____ I do __not__ permit authorization to release or submit billing information to my insurance company.