essexcounselingcenter
LLC

Date _____

Name _____
First Middle Last

Address _____
Street City State, Zip

Date of Birth _____ Age _____ Marital Status _____

Religion _____ Ethnicity _____ Gender _____

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 _____
Name Relationship 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#

Insurance Address _____

Behavioral Health Provider Phone Number – on back of card _____

Policy Holder _____
Name Relation to Client Date of Birth

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.

*You will be provided with a good faith estimate for your understanding of the financial commitment when not using any insurance coverage.