37875 W. 12 Mile Rd. Suite 204
Farmington Hills, MI 48331
(248) 910-1591

CLIENT REGISTRATION

Name: ____ Date: ___________

Address: ____

City: ______________________________________ State: _____ Zip Code: _______

Sex: ____ Marital Status: __________________ Birthdate: ________ Age: _____

SS#: ___________________ Driver's License: State ____ Nr: ______________________

Phone#: Home _______________ Work ________________ _ Cell ___________________
Please, circle preferred number. OK to leave a message? ______ *OK to text?* ______

Health Insurance information:

Insurance Company: ________________________________ I.D. #: ___________________

Policy Group: _____________ Plan/ Program Name: ______________________________

Is the insured same as the client? _____ Client's relationship to insured: _________________

Employer/ School *(Please, circle)*. Name: ____
Full or Part Time *(Please, circle)*

If insured is not the client, OR if there is another health benefit plan, please provide other insured person's:

Name: _______________________________________ Birthdate: __________ Sex:_____

Address (if other than the client's): ____

Phone #: _______________ Employer/ School: ___________________________________

Other Insurance Company: __________________ Plan/Program Name:______________

CLIENT or AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any information necessary to process insurance claims. SIGNED ________________________ DATE______	INSURED or AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned service supplier. SIGNED __________________ DATE________

Please, continue on the other side

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Family Doctor: ___________________________ Phone No.: ___________________

Address: ____

Psychiatrist: _____________________________ Phone No.: ____________________

Address: ____

Other health care professionals involved in your care at this time:

Name:______________________ Specialty_______________ Phone #______________

Name:______________________ Specialty_______________ Phone #______________

Name:______________________ Specialty_______________ Phone #______________

Reason (s) for considering counseling at this time: ________________________________

____

____

How did you find about Lifestart Counseling's services? ___________________________

CONSENT FOR TREATMENT

I, ____, acknowledge that I am voluntarily seeking treatment and that treatment will be rendered by a professional counselor.

I understand that the successful termination of treatment is determined when the counselor and client agree that the goals of treatment are substantially achieved. However, I also understand that I am free to discontinue treatment on my own at any time.

I understand that I may ask questions concerning any part of my treatment.

____ Date _____________

Client Name – Printed

____ Date _____________

Client Signature