

**CARTER COUNSELING**  
**INSURANCE/PATIENT INFORMATION**

**NAME** \_\_\_\_\_  
Last Name First Name Initial  
Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Male \_\_\_ Female \_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_  
Employer \_\_\_\_\_ Position \_\_\_\_\_ Business Phone# \_\_\_\_\_  
Spouse/Partner's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Emergency contact/relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**EAP (Employee Assistance Program) if applicable**

EAP/Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SubscriberID# \_\_\_\_\_ Group# \_\_\_\_\_ Authorization# \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

Company \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_ Telephone# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber's Employer \_\_\_\_\_ Position \_\_\_\_\_ Phone# \_\_\_\_\_  
Subscriber's I.D # \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_\_

**SECONDARY INSURANCE COMPANY**

Company \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_ Telephone# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber's Employer \_\_\_\_\_ Position \_\_\_\_\_ Phone # \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

**I authorize the release of any information necessary and authorize payment of benefits to my therapist from my insurance carrier. I understand any charges are my responsibility regardless of insurance status.**

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**PERSONAL INFORMATION**  
**Each client must complete this page**

What events/situations/issues caused you to seek help here?

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How long have you experienced concerns about these events/situations/issues? \_\_\_\_\_  
Has anyone else in your family had similar issues/problems? \_\_\_\_\_ If so, please explain.

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Have you sought help for this issue/problem before? \_\_\_\_\_  
When? \_\_\_\_\_ Where? \_\_\_\_\_ From whom? \_\_\_\_\_  
What do you hope to change or improve upon through our work together?

What support resources (friends, family, church, spiritual leader, support group) do you have?

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Do you now or have you, in the past?

Smoke(d) cigarettes? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_ When? \_\_\_\_\_  
Drink/drank alcohol? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_ When? \_\_\_\_\_  
Use(d) illegal drugs? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_ When? \_\_\_\_\_

If so, which one(s) \_\_\_\_\_  
Do you have a prior history of addiction or chemical dependency? \_\_\_\_\_ Did you receive treatment? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_ Was it helpful? \_\_\_\_\_  
Do you struggle with other addictive behaviors (eating disorders, pornography)? \_\_\_\_\_  
Do you believe in God or a Higher Power? \_\_\_\_\_  
Do you have a church/temple/mosque/other religious affiliation? \_\_\_\_\_  
Who referred you to me? \_\_\_\_\_

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Primary Physician \_\_\_\_\_ Phone # \_\_\_\_\_ Last Visit Date \_\_\_\_\_  
Other Physicians \_\_\_\_\_  
Medical concerns/conditions \_\_\_\_\_

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Please list prescriptions, medications, dosage, date prescribed:

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**I/we have read and understand the Policies/Procedures Information.**

**If so, please sign and date here: Signature \_\_\_\_\_ Date \_\_\_\_\_**  
**Signature \_\_\_\_\_ Date \_\_\_\_\_**