DEMOGRAPHIC INFORMATION

Today's Date: | **Time:** | **Client No:**

Full Legal Name (First, MI, Last): | **Maiden Name:**

Physical Address: | **County of Legal Residence:**

City/State/Zip: | **Can we send mail to this address?** ☐ Yes ☐ No

Alternative Mailing Address, If Different (or N/A):

Primary Phone: ( ) | **Cell Phone:** ( ) | **Can we send text messages?** ☐ Yes ☐ No

Where may we leave a message? ☐ Primary Phone ☐ Cell Phone

Student: ☐ Yes ☐ No | **Highest Grade Completed:** | **Classes:** ☐ Regular ☐ Special Ed

Marital Status
- ○ Married
- ○ Single
- ○ Divorced
- ○ Widow
- ○ Separated
- ○ Common Law
- ○ Other

Work Status
- ○ Full Time
- ○ Part Time
- ○ Disabled
- ○ Unemployed
- ○ Retired

Employer

Race
- ○ White
- ○ Black/African American
- ○ Native American
- ○ Asian
- ○ Native Hawaiian/ Other Pacific Islander
- ○ Alaskan Native
- ○ Multiracial
- ○ Unknown

Ethnicity
- ○ Puerto Rican
- ○ Mexican
- ○ Cuban
- ○ Other Hispanic
- ○ Not Hispanic or Latino

Client Date of Birth | **Client Age**

Client Social Security Number

Client Gender
- ○ Male
- ○ Female
- ○ Other

Parent/Guardian/Custodian/POA Name and Address: | **Parent/Guard./Cust./POA Phone** ( )

Emergency Contact (Name and Address) | **Relationship** | **Emergency Contact Phone** ( )

Primary Language

Client needs the assistance of an interpreter? ☐ No ☐ Yes If yes: ○ American Sign Language ○ Language: _____

Are you allergic to anything? ☐ Yes ☐ No If yes, please list: _____

Who referred you to this program? | **Family Physician: (Name, Address, Phone)**

Payers- Check all that apply
- ○ Mediciad
- ○ Medicare
- ○ Private Health Insurance
- ○ EAP/AAP
- ○ Title XX
- ○ Direct Fee/Copay:

$ _____

I authorize Pathways Counseling Center, Inc. to release any/or discuss the following information on my behalf to:

Financial and Billing Information To:

(Name)_____

Client/Guard./Cust./POA Initials _____

Appointment Dates & Times inclidung making & cancelling appointments on my behalf to:

(Name) _____

Client/Guard./Cust./POA Initials _____

Gross Monthly Household Income (Total before taxes):

Number of people living in household (including client):

Signature of Acknowledgement: I certify that all information reported is correct. I agree with the client Fee for Service Agreement, the Agreement has been fully explained to me, and I give my permission for this information to be released to my insurance company and/or outside collection service. This is in order to obtain funding and process claims, if eligible, to cover in part or fully, the costs of services provided by Pathways Counseling Center, Inc. I also authorize payment of benefits directly to Pathways Counseling Center, Inc. for services rendered. I authorize my healthcare provider and/or any entity authorized by my health care provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Client's Signature _____ Date _____

Parent/Legal Guardian/Custodian/ Power of Attorney Signature _____ Date _____