

DEMOGRAPHIC INFORMATION

Today's Date:		Time:		Client No:	
Full Legal Name (First, MI, Last):				Maiden Name:	
Address			County of Legal Residence:		
City/State/Zip:			Can we send mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternative Mailing Address, if Different (or N/A):					
Cell Phone: ()		Primary Phone: ()		Can we send text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Where may we leave a message? <input type="checkbox"/> CELL PHONE <input type="checkbox"/> PRIMARY PHONE		EMAIL ADDRESS:		TREATMENT IN LIEU: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Student: <input type="checkbox"/> Yes <input type="checkbox"/> No	Highest Grade Completed:	SCHOOL NAME:		CLASSES: <input type="checkbox"/> Regular <input type="checkbox"/> Special Ed	
Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widow <input type="radio"/> Separated <input type="radio"/> Common Law	Work Status <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Disabled <input type="radio"/> Unemployed <input type="radio"/> Retired	Race <input type="radio"/> White <input type="radio"/> Black/African American <input type="radio"/> Native American <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/ Other Pacific Islander <input type="radio"/> Alaskan Native <input type="radio"/> Unknown	Ethnicity <input type="radio"/> Puerto Rican <input type="radio"/> Mexican <input type="radio"/> Cuban <input type="radio"/> Other Hispanic <input type="radio"/> Not Hispanic or Latino	Client Date of Birth	Client Age
				Client Social Security Number	
	Employer			Client Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="radio"/> American Sign Language <input type="radio"/> Language: _____				
Are you allergic to anything? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____					
Who referred you to this program?		Family Physician: (Name, Address, Phone)			
Payers- Check all that apply <input type="radio"/> Medicaid <input type="radio"/> Medicare <input type="radio"/> Private Health Insurance <input type="radio"/> EAP/AAP <input type="radio"/> Title XX <input type="radio"/> Direct Fee/Copay: \$ _____	I authorize Pathways Counseling Center, Inc. to release any/or discuss the following information on my behalf to:			Gross Monthly Household Income (Total before taxes): \$ _____	
	Financial and Billing Information To: _____ (Name) _____ Client/Guard./Cust./POA Initials _____	Appointment Dates & Times including making & cancelling appointments on my behalf to: (Name) _____ Client/Guard./Cust./POA Initials _____			
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 _____	