DEMOGRAPHIC INFORMATION

Today's Date:	**Time:**	**TREATMENT IN LIEU:** ○ YES ○ NO	**Client No:**

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

Client Social Security Number	**Client Date of Birth**	**Client Age**	**Client Gender** ○ Male ○ Undifferentiated ○ Female

Address	**County of Legal Residence:**	**Can we send mail to this address?** ○ Yes ○ No

City	State	Zip	**EMAIL ADDRESS:**

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

Cell Phone: ( )	**Primary Phone:** ( )	**Can we send text messages?** ○ Yes ○ No **Where may we leave a message?** ○ CELL PHONE ○ PRIMARY PHONE

Highest Grade Completed:	**CLASSES:** ○ Regular ○ IEP	**SCHOOL NAME:**	**Student currently?** ○ Yes ○ No

Marital Status	**Work Status**	**Veteran Status**	**Race**	**Ethnicity**
○ Married ○ Single ○ Divorced ○ Widow ○ Separated ○ Common Law	○ Disabled ○ Homemaker ○ Inmate of Jail ○ Retired ○ Student ○ Unemployed ○ Employed ○ Full Time ○ Part Time Name of Employer:	○ None ○ Active ○ AWOL ○ Dishonorably Discharged ○ Honorably Discharged ○ Medical Discharge ○ Retired	○ White ○ Black/African American ○ Native American ○ Asian ○ Native Hawaiian/ Other Pacific Islander ○ Alaskan Native ○ Unknown	○ Puerto Rican ○ Mexican ○ Cuban ○ Other Hispanic ○ Not Hispanic or Latino

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	**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):**
○ Medicaid ○ Medicare ○ Private Health Insurance ○ EAP/AAP ○ Title XX ○ Direct Fee/Copay: $ ______________	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 ______________	$____________ 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.

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Client's Signature Date

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