ORIGINS COUNSELING CENTER
Beginnings

CLIENT INFORMATION FORM
********* Please Print *********

Date: _____ First Appointment: _____

CLIENT INFORMATION:
Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Birth Date: _____

Cell Phone: (_____) _____ ___Okay to Text Sex: Male _____ Female _____

Work Phone: (_____) _____ Social Security #: _____

Ok to leave message at: __Home __Work __Cell Email: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____

Occupation: _____

In the event of an emergency Origins may contact:
Name _____ Relationship _____
Phone (_____) _____ Home__ Work__ or Cell__
Closest Relative (if different from above)
Name_____ Relationship _____
Phone (_____) _____ Home __ Work__ Cell__

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):
☐ Same as above or

Last Name: _____ First Name: _____ MI_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Birth Date: _____

Cell Phone: (_____) _____ Sex: Male _____ Female _____

Work Phone: (_____) _____ Social Security #: _____

Ok to leave message at: __ Home __ Work __ Cell Email: _____

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PRIMARY INSURANCE INFORMATION:
(*You must complete this section and present a copy of your insurance card for insurance to be billed*)
Insurance Company: _____

INSURED PERSONAL INFORMATION (Subscriber):
Relationship to Client: _____ Employer: _____
I.D. #: _____ Group #: _____

If other than client:
Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ Birth Date: _____
Cell Phone: (_____) _____ Sex: Male _____ Female _____
Work Phone: (_____) _____ Social Security #: _____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to Origins Counseling Center LLC dba Christie VonVille MA, LPC, RN or to Lynn King MA, LPCC-S. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ Date _____

PLEASE NOTE: We do not bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

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ELECTRONIC PAYMENT AUTHORIZATION
Complete only if paying out of pocket

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC, American Express and Discover.

Client Information:
*Client Name: _____ *Date of Birth: _____
*Address: _____ City_____ State: _____ Zip: _____
*Phone: _____

Billing Information:
O **Same as above**
*Name as it appears on card: _____
Billing Address: _____
*Credit/Debit Card Number: _____
*Expiration Date: _____ * CVV Code _____

*I authorize all service fees to be deducted from the card listed above. I authorize the use of this card for all services and fees at the time they are rendered to Origins Counseling Center LLC dba Christie VonVille MA, LPC, RN. I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service.

*By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____
Cardholder Signature Date

_____
Cardholder Printed Name

Payments are processed by Square in accordance with PCI Data Security Standard (PCI-DSS).