Empowerment Counseling Center

The Helping Professionals

Patient Information

Name:_____ Date of Birth_____
First Middle Last

Address: _____
Street City State Zip Code

SSN: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip Code

How did you hear about us? (Check all that apply)

☐ Telephone Listing ☐Friend/Relative ☐Church/Pastor ☐Former Patient/Client ☐ other: _____

Responsible Party

Name: _____ Relationship to Patient _____ SSN: _____

Address: _____ Phone: _____

Employer: _____ Phone: _____

Spouse's Name: _____SSN: _____

Address: _____ Phone: _____

Contact Information for closest relative, not living at above address:

Name:_____ Relationship _____

Address: _____

Home phone: _____Work Phone: _____Cell Phone: _____

Insurance Information: Please show all insurance cards to receptionist.

Primary Insurance Carrier _____Insured Name _____
ID # on Card_____DOB of Insured _____ Effective Date _____
Secondary Insurance Carrier _____ Insured Name _____
ID # on Card_____DOB of Insured _____ Effective Date _____
Other Insurance or HMO? ☐ Y ☐N if yes, name of insurance carrier/HMO_____
ID# on card_____

I hereby authorize Empowerment Counseling Center to release to my insurance company or its representatives any information regarding my treatment including diagnosis that is necessary to process my insurance claim.

I hereby assign all my rights to benefits payable by my insurance company to Empowerment Counseling Center and thereby authorize and request my insurance company to pay my benefits directly to Empowerment Counseling Center.

All insurance information has been listed correctly. I understand that if I have any other health insurance coverage, including and HMO that is not listed above, any charges not covered by the listed insurance, will be my responsibility I understand my co-payment and deductible is due at the time services are rendered. I understand I will be billed for appointments not cancelled 24 hours before the scheduled time. I hereby understand I am responsible for all charges incurred during the course of treatment, including any other services not previously stated. I authorize Empowerment Counseling Center to store and charge my credit card on file for outstanding balances not paid by my insurance providers.

I agree to pay interest at the rate of 33% annum on any unpaid balance if the matter is referred to an attorney for collection and I agree to be responsible for any reasonable attorney fees incurred by Empowerment Counseling Center.

_____ _____
Date Signature

1015 Eden Way N Ste B Chesapeake VA 23320 Office
Office Phone: 757-609-2726 Fax: 757-609-2874

Patient Information

Describe Your Reason for Seeking Help:_____

_____

When were you last examined by a physician? _____

List any major health problems for which you currently receive treatment: _____

_____

List any medications you are currently taking: _____

_____

Have you ever received psychiatric or psychological help, or counseling of any kind before? _____

If you have, please explain: _____

_____

Please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble
Bowel Troubles	Being a Parent	My Thoughts

List the members of your family and all others in your home:

Name	Age/DOB	Relationship	Occupation

Please add any additional information that you feel may be useful to us:

_____

Thank you for completing this questionnaire.

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