Wellness Solutions, LLC

CLIENT REGISTRATION FORM

DEMOGRAPHICS:

Client Name: ____

Client Date of Birth: ____

Client Address: ____

____

Client Phone: ____

I give Wellness Solutions, LLC permission to leave a message at this number: (Circle) YES. NO.

Client Email: ____

I give Wellness Solutions, LLC permission to communicate using this email address: (Circle) YES. NO.

I give Wellness Solutions, LLC permission to use automated appointment reminders for scheduling purposes to this email address : (Circle) YES. NO.

Client's Preferred Method of Contact: ____

Client's Employment/School and Grade: ____

Name of Client's Primary Care Physician: ____

Client's Primary Care Physician Phone Number: ______________________________________

Name of Client's Psychiatrist: ____

Client's Psychiatrist's Phone Number: ____

Client Medical a Conditions: ____

Client Drug Allergies: ____

Client Medications Prescribed By A Physician: _______________________________________

Client Over-The-Counter Medications: ____

Client Previous Mental Health Diagnosis: ____

What is the precipitating event or reason for seeking treatment from the client's point of view?
____

____

What is the precipitating event or reason for the client seeking treatment from a family member's perspective____

____

Approximately how long has the client been experiencing these symptoms?

____

Has the client received treatment for theses symptoms from any healthcare provider in the past 12 months? If so who did the client receive treatment from? What was successful about the treatment? What about this treatment did not work for you? ____

____

PARENT DEMOGRAPHICS UPDATE: (17 YEARS OF AGE AND YOUNGER ONLY)

Parent 1 Name: ____

Parent 1 Address: ____

Parent 1 Phone: ____

I give Wellness Solutions, LLC permission to leave a message for this number: (Circle) YES. NO.

Parent 1 Email: ____

I give Wellness Solutions, LLC permission to communicate using this email address: (Circle) YES. NO.

I give Wellness Solutions, LLC permission to use automated appointment reminders and scheduling purposes to this email address : (Circle) YES. NO.

Parent 1 Preferred Method of Contact: ____

Parent 2 Name: ____

Parent 2 Address: ____

Parent 2 Phone: ____

I give Wellness Solutions, LLC permission to leave a message for this number: (Circle) YES. NO.

Parent 2 Email: ____

I give Wellness Solutions, LLC permission to communicate using this email address: (Circle) YES. NO.

FOR ADOLESCENT CLIENTS ONLY: (Adult Clients Please Skip This Section)

1. If an adolescent client has divorced parents it is required that Wellness Solutions, LLC has a complete copy of the most updated divorce decree and custody agreement. There are no exceptions. Please provide the name of the parent who has primary custody of the client.
____.

2. With whom does the client live at this time? ____.

3. Will both parents be available for counseling sessions, coordination, and related activities?

____.

4. Are there any current legal or custody related issues pending with regard to the client? If so please explain: ____

____.

5. Wellness Solutions, LLC requires that the parent who is consenting for treatment of the client to inform the parent with whom they share custody of said client that he/she is in treatment. Also, as the parent/guardian consenting for treatment I take responsibility for the financial obligations and responsibilities of the client's treatment. I recognize I am responsible for the financial obligations of the client' scare even if the client is utilizing insurance benefits from which I am not a subscriber or member.

(Signature Required) ____.

INSURANCE INFORMATION:

Name of Insurance Company: ____

Member ID: ____

Group Number: ____

Phone Number for Provider Services: ____

Phone Number for Mental Health Services:_______________________________________

Address of Insurance Company: ____

____

Subscriber Name: ____

Company that Policy is Through: ____

Client's Relationship to the Subscriber: ____

Subscriber Date of Birth: ____

Subscriber Social Security Number: ____

Subscriber Phone Number: ____

Subscriber Address: ____

SCHEDULING:

Who is the primary individual we should outreach for scheduling?
____.

Is there a preferred time or day that you need?
____.

I attest that all information provided is accurate and I will inform Wellness Solutions, LLC if any of the above information changes throughout the course of the client' scare. I give Wellness Solutions, LLC permission to submit claims for insurance reimbursement and utilize my insurance benefits for payment of services.
Name: ____

Signature: _____________________________________

Date:____

Wellness Solutions, LLC Witness Signature: ____