



1469 SOUTH MAIN ST
 NORTH CANTON, OH 44720
 330.499.3065 FAX: 330.499.2497

Initial Date of Contact: _____

Counselor: _____

Appointment Date: _____

Appointment Time: _____

CONFIDENTIAL INFORMATION & CONSENT TO TREATMENT: (PLEASE PRINT)

Name of client: _____ Age: _____ Gender: _____
Last First Middle

Home address: _____
Street City State Zip

Birthdate: _____ Phone: Home _____ Cell: _____
 *May we leave a text or voicemail? Yes No

E-mail: _____

Occupation: _____ Employer: _____

Single Married Divorced Separated Other

Spouse's Name: _____ Birthdate: _____

Address (if different from above): _____ Phone: _____
 * May we leave a text or voicemail? Yes No

Employer: _____

Primary Doctor: _____ Practice Name: _____

*Are you willing to sign a form to release information to coordinate treatment with your Primary Care Physician?
 Yes No

Insurance (Aetna, Anthem, Aultcare, Cigna, Med Mutual, Mutual Health, The Health Plan, Ohio Health Choice, PHCS, UBH, Optum, UMR, Summa*) *some plans accepted NO MEDICARE/MEDICAID

Insurance Company: _____ Policy Holder: _____

Member ID: _____ Group Number: _____

Person responsible for payment: _____ Phone: _____

Address (if different from above): _____

Self Pay (1st visit \$150 due at visit, each add'l visit \$125) *Optional sliding fee scale based on qualifications, documentation required

Household Annual Salary: _____ Number of Dependents: _____

REASON FOR COMING:

PREFERENCES / REQUESTS: * New client scheduling may depend on requests (ie. clinician, day or time)

How did you hear about us: _____

Handicapped Access Required? Yes No (**Not all facilities have wheelchair accessibility.*)

I have been given access to the HIPAA Privacy Practices and have the right to request a paper or electronic copy for my personal use.

_____ Initials

I hereby consent to treatment with The Gentle Shepherd Counseling Center. All information provided above is accurate. I agree to payment, of any and all charges accrued, not to exceed twenty five (25) days following date of service.

Date: _____ Signature: _____

Office Staff: _____