

# Alliance Counseling and Education Center

## Client Demographic Form

Please fill this form out completely. You are responsible for providing updates if any information changes.

Today's Date: \_\_\_\_\_

Therapist: Kim England, LCSW

### CLIENT INFORMATION

Full Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Is this your legal name?  Yes  No If not, what is your legal name? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Referred to Provider by: \_\_\_\_\_

### LEGAL INVOLVEMENT

If you are currently involved in a child custody dispute, please complete the following.

Your Attorney's Name: \_\_\_\_\_ Legal Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Is there an Ad Litem or Ambicus Attorney assigned?  Yes  No If yes, who? \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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## Client Demographic Form Continued

### CONTACT AUTHORIZATION

What number can Kim England leave a message on?  Home  Cell

Can Kim England email you?  Yes  No

Can Kim England leave a message with a spouse?  Yes  No

If yes, spouse's name: \_\_\_\_\_

By providing the information listed above, I authorize Kim England to contact me through the approved methods listed above. I reserve the right to revoke this consent by providing Kim England written notice.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### SERVICE YOU ARE SEEKING

Individual Counseling  Couples Counseling  Family Counseling

### IN CASE OF EMERGENCY

Whom may we contact in the event of an emergency? (Please list a local family member or friend not living at the same address).

NAME	RELATIONSHIP	HOME PHONE	WORK/CELL PHONE

### PLEASE READ THE INFORMATION BELOW THOROUGHLY

I understand that I am responsible for payment at the beginning of each scheduled appointment time. I also agree to be fully responsible for full payment of services. I understand that Kim England does not bill insurance at this time and it is my responsibility to research and file for out of network insurance benefits. I understand that Kim England

will provide a detailed receipt upon my request should I chose to submit for out of network insurance benefits.

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Client/Guardian Signature

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Date

I consent to Kim England beginning treatment. I understand that to meet my counseling goals it is best to follow therapeutic suggestions. I also understand that I have the right to discontinue counseling or refuse treatment at any time. I understand that I am responsible for any balance due prior to my decision to discontinue treatment.

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Client/Guardian Signature

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Date