Amanda Sargent LMHC
2915 E. Madison #208
Seattle, Washington 98112
(206)264-4401

Client Information

Name_____Date of Birth_____

Address:_____

Email Address:_____

Home Phone_____Cell Phone_____

Work Phone_____

Which number may I leave a voice message on?_____

Is it okay to leave an appointment related message on home phone?_____

How did you hear about me?_____

Have you ever been in counseling before?_____

Names and numbers of two emergency contacts:

_____relationship_____

_____relationship_____

Do you have any medical conditions I should know about? i.e. epilepsy, seizures,

life threatening allergies?_____

Are you currently taking any medications? Y_____N_____

If yes, please list names and dosages_____

_____

_____

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Insurance information:

Company:_____

Address:_____

Phone:_____

Group #:_____ **ID #:**_____

Name of subscriber:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:

I authorize Amanda sargent MA, LMHC to:

1) **Furnish my insurance company with any/all information requested concerning my present claims.**

2) **Bill my insurance company and accept payment from that company on my behalf for all services relating to my care.**

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that there is no guarantee that my insurance will pay all or a portion of charges incurred by me. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including but not limited to, collection costs, attorney's fees, and all court costs.

_____ _____

Responsible parties signature **Date**