FOCUS Institute Of Stillwater, LLC
CLIENT INFORMATION

(Please Print Clearly)

Personal Information

Name ________________________________ SSN ______________________ Date _______________

Address ________________________________ City, Zip ____

DOB _______________ Phone ________________ May we Leave a Message: Yes ( )   No ( )

E-Mail___________________________ ( ) single ( ) married ( ) separated ( ) divorced ( ) widow(er) ( ) student

Spouse's Name__________________________ Spouse's address (If different from above) ____________________

Spouse's Phone__________________________ Spouse's E-Mail____________________________________

Children:

Name	Date of Birth	Age	Grade (if in school)

Client Work Information

Employment _____________________ How Long _______________ Hours: from _________ to ________

Job Description ________________________________ Work Phone _________________ Ext ___________

Spouse's Work Information

Employment _________________ How Long ____________________ Hours: from _________ to _________

Job Description__________________________________ Work Phone ______________ Ext ____________

Emergency Contact Information

Name ________________________________ Address ________________________ Phone ____________

SSN _______________________________________ DOB ________________

Address & Phone ____

How can we help you today? ____

I have read and been offered a paper copy of Focus Institute's <u>NOTICE OF PRIVACY PRACTICES.</u>

I agree to participate in a Confidential Client Satisfaction Survey: Yes____ or No____. I prefer that it be by Phone_____ or E-Mail_____.

I acknowledge that my signature gives authorization for Focus Institute to bill my insurance for therapeutic services that go beyond the EAP visits. I authorize payment from my insurance company to Focus Institute for their services billed. I understand that I am responsible for any amount that Insurance does not cover.

___________________________________ ________________________

Client Signature/Responsible Party Signature Date