# Kairos Counseling, LLC

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This information is for internal use only and is intended to establish a complete and confidential portfolio for each client. Please print clearly and provide all of the requested information. Feel free to discuss any questions or concerns with Carol

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Name_____

Date of Birth _____ Age_____ Gender _____

Email_____

Address_____

City_____State_____Zip_____

Home: ( )_____ Work ( )_____Cell:( )_____

May we leave a voice mail message at: Home Yes No Work: Yes No Cell : Yes No

Employer_____ Position_____

How long?_____

Marital status: ___Single ___Married ___Divorced ___Separated ___Widowed

How long? _____

Do you attend church?_____ Name: _____

Are you a member?_____ _ Denomination _____

<u>Emergency Contact</u>

Name _____

Relationship _____

Telephone _____

RESPONSIBLE FAMILY MEMBER INFORMATION or SPOUSE IF MARITAL COUNSELING::

Name_____

Date of Birth _____ Age_____ Gender Email_____

Address_____

City_____State_____Zip_____

Home: ( )_____ Work: ( )_____ Cell: ( )_____

May we leave a voice mail message at: Home Yes No Work Yes No Cell Yes No

Employer_____ Position_____

SPOUSE/DEPENDENT INFORMATION

| Name | Age | M/F | Relation to Client |
|---|---|---|---|
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I would like to receive a monthly statement to file with insurance or medical reimbursement company. Yes No

In order to process your insurance claim, a release from you to be kept on file is required.

I hereby authorize the release of any medical or other information reasonable or necessary to process claims to my insurance company. I also hereby authorize payment of medical benefits from my insurance company to Kairos Counseling, LLC, for services provided.

_____

Signature of Client Date

_____

Signature of Responsible Family Member Date