Kelly Peck Counseling, LLC
1944 Pacific Avenue, Suite 309, Tacoma WA 98402
Phone: (253) 227-7639 Fax: (253) 572-9958

CLIENT INFORMATION:

Date: __________________

Identification Information:

Client Name: _______________________________ **M.I**.: ________

Age: ________ Male / Female Date of Birth: _______/_______/________

Parent(s)/Guardian(s) Name(s): ____
(Only if client is under 18 yrs old)

Home Phone: (______) _______-__________ Ok to call regarding appointments? Yes / No

Cell Phone: (______) _______-__________ Ok to call regarding appointments? Yes / No

Address: ____

City/State: _______________________________ Zip: __________________

E-mail address: ____

PRIMARY INSURANCE: _______________________________________

Subscriber's Employer: ____

Subscriber's Name: _________________________________ M.I.: ________

Date of Birth: ______/______/_______ Member I.D. #: ________________________

Group #: _____________________

Address (if different from client): _____________________________________

City/State ___________________________Zip: _________________

Home Phone: (_____) _______-__________ Cell: (______) _______-___________

The conditions of billing your insurance, collecting payments and client financial responsibility for uncovered costs, co-pays and/or deductibles is outlined in the DISCLOSURE, CONSENT FOR TREATMENT, CLIENT RIGHTS AND FINANCIAL AGREEMENT/FEE POLICY form.