

**Woodhaven Counseling Associates, Inc.**  
**NEW CLIENT INFORMATION—2020**

Date \_\_\_\_\_

Client No. \_\_\_\_\_

**Client Information**

Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  - M  - F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Work/School Phone: \_\_\_\_\_ Okay to call?  Yes  No  
Home Phone: \_\_\_\_\_ Okay to call?  Yes  No Cell Phone: \_\_\_\_\_ Okay to call?  Yes  
 No  
Email: \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Religious preference: \_\_\_\_\_ Highest Grade Completed \_\_\_\_\_  
Has the client had previous counseling/therapy?  - None  - Office (outpatient services)  - Hospital  
Is the client taking prescribed medication?  - No  - Yes (specify all & Dr.): \_\_\_\_\_

*In Case of Emergency, Contact:* Name: \_\_\_\_\_  
Relationship to client \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Who may we thank for referring you to us? \_\_\_\_\_

**If the client is a minor child, a biological parent or legal guardian must complete this section**

If the child's parents are divorced, to which parent has the court given custody?

- Mother  - Father  - Joint  - Other \_\_\_\_\_

Your Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  - M  - F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Sec. Number: \_\_\_\_\_ Your Relationship to client: \_\_\_\_\_  
If applicable, please list name and contact information for the non-custodial parent: \_\_\_\_\_

If applicable, please list name and contact information for child's caseworker: \_\_\_\_\_

**Family Information**

*Please list everyone living in the client's home:*

Name	Age	Sex	Relationship	Name	Age	Sex	Relationship
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Does the client have children who are not living in the home?  - No  - Yes

**Insured Person's Information**

Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  - M  - F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Sec. Number: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Insurance ID or Group No.: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_

**Please Continue on Other Side of Form**

## Consent for Treatment

I \_\_\_\_\_ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Woodhaven Counseling Associates, Inc., a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

\_\_\_\_\_  
Signature of Client, Parent/Guardian

\_\_\_\_\_  
Date

Relationship to Patient (if applicable): \_\_\_\_\_

## Consent for Use and Disclosure of Health Information

I give my consent for the use or disclosure of mine or my child's protected health information (PHI) by the staff of Woodhaven Counseling Associates, Inc. for the purpose of treatment, payment, and healthcare operations. By signing this form, I am agreeing to let WCA, Inc. use my information and send it to others. The Notice of Privacy Practices explains this in more detail. **I have received the Notice of Privacy Practices and understand I should read it before signing this consent.**

- ✧ I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, WCA, Inc. cannot treat me and/or my child (ren).
- ✧ WCA, INC. reserves the right to change its privacy practices. In this case, all current or revised Notices of Privacy Practices may be obtained from WCA, Inc.'s Privacy Officer.
- ✧ I have a right to request (in writing) a restriction of how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations. WCA, Inc. is not required to agree to the restrictions that I may request. However, if WCA, Inc. agrees to a restriction that I request, the restriction is binding on WCA, Inc. Additionally, I understand that I have the right to revoke this consent, in writing, at any time.
- ✧ My PHI means health information, including demographic information, collected from me and created or received by my physician or health plan. This PHI relates to my past, present or future physical or mental health or condition and identifies me or my child.

\_\_\_\_\_  
Signature of client,  
parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Client's Name

Copy given to Client or Parent/Legal Guardian