Woodhaven Counseling Associates, Inc.
NEW CLIENT INFORMATION—2021

Date ______________________ Client No. ________________

Client Information

Legal Name: ____ Nickname / Alias:_____________________ Birth Date: _________________

Age: ________ Gender at Birth: □- M □- F Identified Gender: _________________ Preferred Pronouns: ______________________________

Address: ____ City: ________________________ State: ________ ZIP: ______________

Primary Phone: ______________________ □ Hm □ - Mobile Secondary Phone: _________________________ □ - Hm □ - Mobile

Employer/School:______________________________________ Work/School Phone: ______________________ Okay to call? □ Yes □□No□

Social Security Number __________________________ Email: _______________________________________ Marital Status__________

Religious preference: ______________________ Highest Grade Completed ___________

Has the client had previous counseling/therapy? □- None □ - Office / Outpatient □ - Hospital

Is the client taking prescribed medication? □ - No □ - Yes (specify all & Dr.): ____

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In Case of Emergency, Contact: Name: ____ Phone: ______________________________

Relationship to client _______________________ 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:____

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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 Security Number: __________________________ Relationship to client: ________________________

Insurance Co.: ____________________________________ Member ID.: ______________________________ Group: _________________

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