WESTSIDE CENTER
for COUNSELING and THERAPY
205 S. Minnesota Street
Carson City, NV 89703-4269

Therapist: _____
Appointment Date/Time: _____

Application for Services

Name of Client_____ Referred by:_____

_____
Address City State Zip

Telephone: Home( )_____ Business ( )_____ Cell ( ) _____
May we leave a message? Yes____No____ Yes____No____ Yes____No____

Soc. Sec. or Medical ID #____/____/____ Date of Birth____/____/____ Married ( ) Single ( ) Other ( )

If Client is a Minor, please list Parent or Guardian and address information:

Parent or Guardian:_____

_____
Address (if different from Client) City State Zip

Employer:_____Address:_____

Primary Care Physican:_____Address (City/State is fine):_____

Spouse:_____

Soc. Sec or Medical ID #_____/_____/_____ Date of Birth: _____ _____ _____

Spouse's Employer:_____ Address:_____

Insured (if not client):_____ **Insurance Co**._____

Address:_____

Policy #_____ Group #_____ Phone: (____)_____

FAMILY MEMBERS

_____ Date of Birth _____/_____/_____

_____ Date of Birth _____/_____/_____

_____ Date of Birth _____/_____/_____

_____ Date of Birth _____/_____/_____

I am seeking help because_____

_____

I understand that a "per session" charge may be made for non-kept appointments or appointments canceled without 24 hour notice.

I agree to pay the per hour fees or appropriate insurance co-payment for services provided. I understand that I am responsible for the total incurred fee although my insurance may be billed for the service.

I agree to assign insurance benefits for the above mentioned insurance company.

_____ _____
Client Signature or Parent/Guardian Date

_____ _____
Parent/Guardian (if joint custody) Date