Snowy Albright, MTS, LPC

4032 Masonboro Loop Road #103
Wilmington, NC 28409

Please complete the following to help your counselor better assess your situation. This information will be kept confidential. If you are completing this as a parent or guardian of a prospective client, please give information pertaining to that person.

Client's Full Name:_____ Today's Date:_____

Address:_____
Street or PO Box

_____
City State Zip Code

Telephone: Home:_____ Cell:_____ Work: _____

Age:_____ Birthdate:_____ SS#:_____

Employer or School (if student):_____

How did you hear about me? _____

Emergency Contact:_____
Name Relationship Phone

Insurance Information

Insurance Company:_____ Name of Insured:_____

Insured's SS#:_____ Insured's Birthdate:_____

Insured's Policy #:_____ Insured's Group #:_____

Insured's Employer:_____ Amount of Co-Pay:_____

Insured's Relationship to Client:_____

Authorization #:_____

To Be Completed By Therapist

Primary Diagnosis:_____ Secondary Diagnosis: _____

Treatment Agreement

Please Initial:

_____ Co-payments are due at the time of service.

_____ I hearby assign payment of insurance benefits directly to Snowy Albright. While Snowy Albright will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay.

_____ It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied, I will be responsible for all charges.

Personal Information

Marital Status

____ Single
____ Married (date_____)
____ Separated (date_____)
____ Divorced (date_____)
____ Widowed (date_____)
____ Remarried (date_____)

If applicable:
Current spouse's name:_____
age:_____
Please give information about previous marriages:____
_____
_____

Family Information

Is your mother living? ____ Yes ____ No Is your father living? ____ Yes ____ No
If you were raised by anyone other than your biological parents, by whom? _____
If you have children, how many and what ages? _____
_____
Are you adopted? ____ Yes ____ No
Are all of your children living? ____ Yes ____ No If NO, Please explain:_____
Your education level:_____

Medical Information

How would you describe your health? _____
Has there been any change in your weight in the past year? ____ Yes ____ No
If YES, please explain:_____
Has there been any change in your sleep patterns in the past year? ____ Yes ____ No
If YES, please explain:_____
Physician's Name:_____
Date and Report of last physical:_____
List serious injuries or illnesses in past ten years:_____
_____
_____
List any medications and for what purpose taken:_____
_____
_____

Have you had counseling in the past? ____ Yes ____ No

If YES, when? _____ By whom? _____

For what purpose? _____

Would you be willing for this document to serve as a Release of Information form giving permission to obtain records from your previous counselor or the referring physician?____ Yes ____ No (Please initial).

Describe briefly the major concern that brings you for counseling at this time.

Indicate what you have done about it prior to this appointment.

As you see yourself, what kind of person are you?

* I understand that because the counselor has reserved time exclusively for me it is absolutely essential that I notify the counselor at least 24 hours in advance if it is necessary to cancel my appointment. I understand that I will be charged my regular fee, or a portion thereof, for “no show” or late cancelations with the exception of illness or emergencies.

Signature_____ Date_____