KoKoRo Counseling & Integrated Health Services

Healthy-Living/Wellness Training, Coaching, Counseling

P.O. Box 70494 Houston, TX 77270 PH: 832.632.8118 yourwellbeingmatters@gmail.com

(Fax completed form to 713.422.2428 & notify office. Fax must be received to reserve your first appointment)

Patient / Client Information Sheet

Referred By: _____ Today's Date: _____
Referred or seeking service for presenting issue of _____

Client Name: _____ Gender: _____ SS#: _____-_____-_____

Date of Birth: _____ Driver's License #& State Issued: _____

Permanent Address: _____ E-mail* _____
City: _____ State: _____ Zip: _____ May we send emails to you @ above address? Yes / No

Cell/Home Phone: _____ Work/Alternate Phone: _____
May we (circle ea.) Text / leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Marital Status: (Circle one) single / engaged / co-habitating / partnered / married / separated / divorced / widowed / other
(explain) _____

Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____ Has your Employer Referred You? Yes / No
Are you currently involved in any legal issues / litigation? Yes / No ; or a current Workman's Comp Case? Yes / No

Primary Care Physician: _____ Phone#: _____
Current Psychiatrist: _____ Phone#: _____

RESPONSIBLE PARTY INFO (If someone other than client will be paying for services or is legal guardian):
Name: _____ Gender: _____ SS#: _____-_____-_____
Relationship to Client: _____ Date of Birth: _____
Address: _____ E-mail* _____
City: _____ State: _____ Zip: _____ May we send emails to named @ above address? Yes/No
Cell/Home Phone: _____ Work/Alternate Phone: _____
May we (circle ea.) text / leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No
Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone#: _____ Evening Phone#: _____
Work Phone#: _____ Mobile#: _____

Payment of Services: I will pay for services myself** as "Fee for Service" Yes / No (Initial :_____)
I give Auth of Benefits & Billing to KoKoRo Counseling & Integrated Health Services, as network-provider Yes / No Initial :___
I choose KoKoRo Counseling & Integrated Health Services as non-network-provider & need a receipt ea. visit Yes / No Initial :__
If using insurance, please continue & complete 'Benefits Verification Forms & Fax back with Copy of Benefits Card & DL. to start.

My signature below indicates I authorize the release of any medical or other information necessary for processing and payment of services due to/via KoKoRo Counseling & Integrated Health Services or affiliate provider of client above.

Client Signature: _____ Date: _____
Or Legal Guardian's Signature: _____ Date: _____