KoKoRo Counseling & Integrated Health Services

Counseling, Healthy-Living & Wellness Coaching, Biofeedback Training

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

(Fax/Mail completed form to 713.422.2428 & notify office. We must receive to reserve your 1st appointment)

Patient / Client Information Sheet

Referred By: ______________________________ Today's Date:____________________

Referred or seeking service for presenting issue of ______________________________

Printed 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 ("X" best.) Text/ leave a message @ above PH#? __Yes/__No *May we leave a message @ above PH#? __Yes/__No

Marital Status ("X"best)__single __ engaged __ co-habitating __ partnered __ married __ separated __ divorced __widowed __ other (explain)____

Occupation: ____ Employer: __________________________________

Employer's Address: ____

City: _________________________________State: _______Zip: ___________("X" best) Employer Referred You?__ Yes__ No

Current legal issues/litigation? __Yes/__No; Current Work-Comp Case? __Yes/__No; Current Disability Case? __ Yes/__No

Primary Care Physician: ___________________________________ Phone#: _________________________________

Current Psychiatrist: ______________________________________ Phone#: _________________________________

RESPONSIBLE PARTY INFO (If someone other than you will pay for services or is legal guardian for a ward/minor):

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 (X best.) 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'll pay for services myself as "Fee for Service" because I do not have benefits. __Yes/__No (Initial:______)

I'll pay for services myself as "Fee for Service" because I OPT-OUT of using my benefits. __Yes/ __No (Initial:_________)

I authorize Billing/Benefits to KoKoRo Counseling & Integrated Health Services/Headway, as In-network __ Yes/__No (Initial: _)

I'll pay for services/submit claims myself or use ADVEKIT for payment& claims as Out-of-Network __Yes/__No (Initial: _____)

Please complete 'Benefit" Forms (or HEADWAY/ADVEKIT) & Fax back w/ Photo/Copy of Benefit Card & DL, front & back.

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

Patient Signature: ____ Date: ________________________________

Or Legal Guardian's Signature: ________________________________ Date: ________________________________