Comprehensive Counseling Center
2358 Route 9 South
Howell, New Jersey 07731
Phone: 732-987-9770

Client Information

Client's Name____ Email Address __________________________________

Street____Apt. #__________________________

City____State___________Zip Code_________________________

Home Phone ___________________________________ Cell Phone____
____ permission to call/leave msg. ____ permission to call/leave msg.

Age_____________ Date of Birth______________________________ SS#____

Marital Status:_____ Single____ Married____ Separated___ Divorced _____Widowed

Emergency Contact____Telephone______________________________________

Primary Insurance
Company ____Telephone______________________________________

ID#____Group#_____________________Effective Date____________________

Subscriber's Name_______________________________________ Employer____

Relationship to Client: ___Self ____Spouse ____Parent

Subscriber's Date of Birth__________________________ Subscriber's SS#___________________________________

Address to Submit claims:____

Authorization number ___________________________ co-payment/coinsurance $_________________________

Deductible $_____________________ Number of visits allowed per year______________

I authorize the release of medical information necessary to process insurance claims

associated with my treatment by____
(name of therapist/facility)

I permit a copy of this authorization in place of the original.

Signature____Date_______________________

I authorize payment of medical benefits to ____
(name of therapist/facility)

for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either my insurance Company or I may revoke this authorization in writing at anytime.

Signature____Date________________