Peace of Mind Counseling, Consulting, and Supervision LLC
4025 Holt Road Suite 205
Holt, MI 48842-6019
(517) 881-7231
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http://www.peaceofmindccs.com

Client Information

Name: ____________ (Last) ____________ (First) ____________ (MI)

Phone: ____________ (Main) ______ (Type) ____________ (Alternate) ______ (Type)

Street: ____________ Apt/Ste: ____________

City: ____________ State: ____________ ZIP: ____________

Email: ____________

DOB: ____________ Gender/Pronoun: ____________

Marital Status: ____________ Employment Status: ____________

SSN: ____________ Referred by: ____________

Guardian Information

Name: ____________ (Last) ____________ (First) Phone: ____________

Street: ____________ Apt/Ste: ____________

City: ____________ State: ____________ ZIP: ____________

Primary Insurance Information

Name: ____________ (Last) ____________ (First) ____________ (MI)

Phone: ____________ Email: ____________

Street: ____________ Apt/Ste: ____________

City: ____________ State: ____________ ZIP: ____________

DOB: ____________ Gender: ____________

SSN: ____________ Employer: ____________

Insurance ID: ____________ Group #: ____________

Insurance Provider: ____________ Relation to Client: ____________

Secondary Insurance Information

Name: ______ ______ ______
(Last) (First) (MI)

Phone: ______ Email: ______

Street: ______ Apt/Ste: ______

City: ______ State: ______ ZIP: ______

DOB: ______ Gender: ______

SSN: ______ Employer: ______

Insurance ID: ______ Group #: ______

Insurance Provider: ______ Relation to Client: ______

By signing below, I acknowledge that I am either the client, the primary insurance holder, or another person authorized to sign on behalf of the client named above. I authorize the release of any medical or other information necessary to process claims for services provided. I authorize payments of medical benefits to **Peace of Mind Counseling, Consulting, and Supervision LLC**.

Signed: ______ Date: ______

Therapist Signature: ______ Date: ______

Diagnosis: ______ | ______ | ______ | ______ | ______