Healing Waters Counseling Center, LLC.

Director: Bradley T. Kinder, M.S., LPC, CSAC
Licensed Professional Counselor
Certified Substance Abuse Counselor

Thank you for choosing Healing Waters Counseling Center, LLC. In order to serve you properly, we will need the following information. (Please print). All information will be strictly confidential.

Patient Name: _____ Today's Date: _____
Address: _____ Referred By: _____
City: _____ State: _____ Zip: _____ Phone: _____
Email: _____ Cell: _____
Is the patient in foster care? ☐ Yes ☐ No If so, list name of foster care worker: _____
Has the patient been seen at **Healing Waters** before? ☐ Yes ☐ No If yes, when? _____

Sex: _____ Age: _____ Marital Status: _____ Date of Birth: _____
Occupation: _____ Patient's Social Security #: _____
Education: _____ Rate your health: ☐ Excellent ☐ Good ☐ Poor
Do you feel you are a danger to yourself or anyone else right now? ☐ Yes ☐ No
Briefly describe your reason for seeking help: _____
_____
List any medications you are now taking and dosages: _____
_____
Have you been in counseling/therapy before? If yes, when and for what reason(s)? _____
_____

Employer/School
Address, City, State, Zip, Phone
_____
_____
_____

Are you seeking services for the purposes of filing a disability claim? ☐ Yes ☐ No

**Employee Type:**
Retired ☐
Employed Full Time ☐
Employed Part Time ☐
Not Employed ☐

**Student Type:**
Student, Full Time ☐
Student, Part Time ☐

**Insurance Information: (Please complete thoroughly)**
Insured: _____ Sex: _____ Date of Birth: _____
Relationship to patient: _____ SSN: _____
Address of Insured if different from patient: _____
_____
Policy Number: _____ Group Number: _____
Authorization Number: _____
Employer: _____ Employer's Address: _____

**Please sign and date the release/assignment below:**

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to this Provider.

_____ _____
Client (18 or over) or Guardian Date