JOHN HAWKINS, LPC
POB 172, Brookhaven, MS 39601

CLIENT DATA FORM

NAME: ____________________

ADDRESS: ____________________

____

PHONE: ____________________ **E-MAIL:** ____________________

DATE OF BIRTH: ____________________

SOCIAL SECURITY NUMBER: ____________________

EMPLOYER: ____________________

EMPLOYER ADDRESS: ____________________

BUSINESS PHONE: ____________________

NAME OF SPOUSE OR PARENT: ____________________

SPOUSE OR PARENT PHONE: ____________________

SPOUSE/PARENT ADDRESS (if different from above): ____________________

____

* * * * *

Who referred you to me? ____________________

What do you hope to gain from counseling? ____________________

____

____

____

____

____

____

JOHN HAWKINS, LPC
CLIENT INSURANCE INFORMATION

(NOTE: We do not file insurance for office visits. Office Visits are paid at the time of service, either by check or cash. We do not take charge cards or debit cards. We also do not take Medicaid or Medicare.)

INSURANCE COMPANY 1

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Policy Holder: ______________________________

Insurance Number: ______________________________

Group Number: ______________________________

INSURANCE COMPANY 2

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Policy Holder: ______________________________

Insurance Number: ______________________________

Group Number: ______________________________

RELEASE OF INFORMATION:

I hereby authorize John Hawkins, LPC to release to insurance company any information to process my claim.

____

Client Signature (Parent Signature if under 18) **Date**