



Please circle any of the following problem(s) that pertain to you (adult).

- |                    |                      |                         |                |
|--------------------|----------------------|-------------------------|----------------|
| nervousness        | depression           | fears                   | shyness        |
| separation/divorce | sexual problems      | abuse/domestic violence | finances       |
| suicidal thoughts  | drug use             | alcohol use             | friends        |
| anger              | self-control         | hearing voices          | sleep          |
| stress             | work                 | relaxation              | headaches      |
| violent thoughts   | memory               | ambition                | legal matters  |
| energy             | insomnia             | making decisions        | loneliness     |
| concentration      | inferiority feelings | education               | marriage       |
| health problems    | temper               | nightmares              | career choices |
| children           | appetite             | stomach trouble         | bowel trouble  |
| parenting          | my thoughts          | sexual identity         | tiredness      |
| internet/computer  |                      |                         |                |

If you are seeking help for your child, please circle any of the following problem(s) which concern you.

- |                 |                           |                      |                     |
|-----------------|---------------------------|----------------------|---------------------|
| stealing/lying  | tiredness                 | clumsiness           | suicidal thoughts   |
| eating problems | over-activity/hyper       | school problems      | sex problems        |
| under-activity  | running away              | shyness              | easily upset        |
| toilet problems | fears                     | self-critical/guilty | temper tantrums     |
| over-dependency | depression                | aggression           | jealousy/resentment |
| destructive     | sleep problems/nightmares | cruelty              | health problems     |
| nervousness     | over-sensitive            | unusual habits       | physical complaints |

**INSURANCE INFORMATION (MUST BE COMPLETED)**

Person responsible for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Policyholder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 Insurance Plan: \_\_\_\_\_ Address: \_\_\_\_\_  
 I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

**If other insurance:**

Policyholder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 Insurance Plan: \_\_\_\_\_ Address: \_\_\_\_\_  
 I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Signature On File & Assignment/Release**

I authorize use of this form on all my insurance submissions. I further authorize release of information to all my insurance carriers and/or managed care companies. I authorize Psychology and Counseling Associates to act as my agent in helping me obtain payment from my insurance carriers. I understand that I am financially responsible for any non-covered services or unpaid balances. I authorize payment directly to Psychology and Counseling Associates, P.C. I permit a copy of this authorization to be use in place of the original. I verify that the answers to the above questions are true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_