California Center for Healing

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THIS INFORMATION WILL BE KEPT CONFIDENTIAL

Date _____ Email Address _____

Name _____ Birth Date _____
(First) (Last)

Address _____
(Street) (Suite/Apt #)

_____
(City) (State) (Zip)

Check if you want monthly statement mailed to this address ☐

Spouse Name _____ Birth Date _____

		Yes	No
Her Home Phone _____	ok to lv message	_____	_____
Her Work Phone _____	ok to lv message	_____	_____
Her Cell Phone _____	ok to lv message	_____	_____
His Home Phone _____	ok to lv message	_____	_____
His Work Phone _____	ok to lv message	_____	_____
His Cell Phone _____	ok to lv message	_____	_____

Children's Names	Date of Birth	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referred by _____ Physician name _____
Address_____ Phone #_____
OK to thank referral? Yes_____ No_____

Previous Psychotherapy Yes_____ No_____ If yes, Therapist Name _____

Employer _____ Employer Location (City, State) _____

Insured's Soc Sec # and Name_____
(List above information ONLY if you request an insurance "superbill" mailed to you on a monthly basis).

I understand that payment will be made at the time of each session and I hereby assume full responsibility for the expenses incurred in the care of the client listed above. I understand that I am responsible for all charges, regardless of insurance coverage and am responsible for any charges incurred in collection efforts.

Sign: _____ Date: _____

FOR OFFICE USE ONLY

Therapist: _____

Returning Client: Yes No

Primary Procedure Code:

Individual	90806
Conjoint	90847
20-30 Min	90804
75-80 Min	90808
Initial Eval	90801
Group	90853

Individual Rate: _____

Conjoint Rate: _____

Initial Eval Rate: _____

DSM IV Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current GAF_____