ACUMEN
COUNSELING SERVICES, LLC

Client Data Sheet

Full Name: _____ **Date of Birth**: _____

How did you hear about us? ❑Internet Search ❑Referred by a past client ❑Referred by another Provider

Other: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Is this your mailing address? ❑Yes ❑No *(if no, please list mailing address below):*

Street Address: _____

City:_____ State: _____ Zip:_____

Phone Numbers:	May we contact you at this number?	May we leave a message?
Home: _____	❑Yes ❑No	❑Yes ❑No
Mobile: _____	❑Yes ❑No	❑Yes ❑No
Work: _____	❑Yes ❑No	❑Yes ❑No

Email: _____

Would you like to receive:
An appointment reminder on the day of your appointment? ❑Yes ❑No
An appointment reminder prior to the day of the appointment? ❑Yes ❑No
(If so:) ❑ 1 Day Prior or ❑ 2 Days Prior or ❑ 3 Days Prior
Receive reminders via ❑ Email or ❑ SMS Text to your Mobile Number

Employment Status:

Employed: ❑Full-time ❑Part-time **Student:** ❑Full-time ❑Part-time

Unemployed: ❑ Seeking Work ❑ Not Seeking Work ❑ Disabled ❑ Other _____

(If employed) Occupation: _____ Employer's Name: _____

(If student) Name of School: _____ Year in School: _____

Employer/School Address: _____

City: _____State: _____ Zip: _____

Martial/Relationship Status:

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed/Widower ❑ In a Long-Term Relationship

❑ Living Together ❑ Engaged ❑ Other _____

Spouse/Significant Other's Name (if applicable): _____

Emergency Contact Name: _____

Relationship to Client: _____ Phone Number: _____

PRIMARY INSURANCE: (Copy of Insurance Card taken if possible)

Insurance Company Name: _____

Insurance ID Number:_____ Group Number: _____

Subscriber's Name:_____Relationship: _____

Subscriber's Birth date:_____Subscriber's Phone Number: _____

Subscriber's Address: _____

City:_____ State: _____ Zip: _____

Co pay Amount *(if applicable): $*_____ Coinsurance Percentage *(if applicable):*_____

Do you have a deductible? ❑Yes Amt $_____ Have you reached it? ❑Yes ❑No ❑ Unsure

SECONDARY INSURANCE *(if applicable):* **(Copy of Insurance Card taken if possible)**

Insurance Company Name: _____

Insurance ID Number:_____ Group Number: _____

Subscriber's Name:_____Relationship: _____

Subscriber's Birth date:_____Subscriber's Phone Number: _____

Subscriber's Address: _____

City:_____ State: _____ Zip: _____

TERTIARY INSURANCE *(if applicable):* **(Copy of Insurance Card taken if possible)**

Insurance Company Name: _____

Insurance ID Number:_____ Group Number: _____

Subscriber's Name:_____Relationship: _____

Subscriber's Birth date:_____Subscriber's Phone Number: _____

Subscriber's Address: _____

City:_____ State: _____ Zip: _____

Client Signature: _____ **Date:**_____

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Informed Consent to Treatment for Therapy Clients

I, the client, acknowledge that I have been offered, received and reviewed the documents:

- Information for Therapy Clients
- Confidentiality in Therapy
- Access to Health Records Notice of Rights
- Minnesota Patients' Bill of Rights

I have discussed any points I did not understand, and I have had my questions, if any, fully answered. If at any time during my treatment I have additional questions about any of the subjects discussed in these documents, I will bring them up to my therapist, who will do his or her best to answer them.

I consent to enter into treatment in the form of therapy sessions with the therapist whose name appears below. I understand that my signature below does not indicate that I am waiving any of my rights. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur and to work them out in my long-term best interests.

I agree to pay for all services rendered to me by this therapist, as outlined in the policies and procedures contained in the documents provided to me. I also agree to pay the missed session fee when I fail to give the notice required by the policies and procedures.

I understand that if I choose to use my insurance benefits, I will remain fully responsible for this therapist's fee; however, this therapist will bill my insurance and follow any other necessary administrative procedures, as agreed in his or her contract with my insurance company. For this purpose, I give permission for my therapist to communicate with my insurance company about my condition and treatment and to receive payment on my behalf.

ACKNOWLEDGMENT OF PRIVACY PRACTICES
HIPAA, Records other Privacy Practices

I further acknowledge that I have been offered a copy of "Notice of Privacy Practices" from Acumen Counseling Services, LLC. I reviewed the same with my therapist and any relevant questions have been addressed. I understand that I can obtain any additional copies as needed by contacting my therapist and requesting one.

_____ _____
Client Signature Date

_____
Client Printed Name

_____
Witness Signature

I, the therapist, have met with this client for a suitable period of time, during which I have reviewed the above-enumerated documents, discussed relevant issues and points, and responded to the client's questions to the best of my ability. I believe this client fully understands the information contained in the documents, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with this client, as shown by my signature below.

_____ _____
Therapist Signature Date

_____
Therapist Printed Name