KETTLE MORAINE COUNSELING
400 W River Drive West Bend WI 53090
W62 N281 Washington Ave Cedarburg WI 53012
7280 S 13th Street Oak Creek WI 53154
P: 262.334.4340 F: 262.334.4341 www.kettlemorainecounseling.com

Therapist:_____

Client's Name_____ _____Preferred Name:_____

(Last) (First) (M.I.)

Address_____ _____ _____ _____

(Number and Street) (City) (State) (Zip)

Home Number_____ ____Work Number_____Mobile _____ Ok to text?_____

Email_____OK to email?_____ Gender_____ Pronouns_____

Date of Birth_____Social Security #_____Marital Status: M S W D Separated

Spouse's Name_____Employer_____

IF CLIENT IS UNDER 18:

Name of Parent or Guardian_____

Address of Parent or Guardian_____ _____ _____ _____

(Number and Street) (City) (State) (Zip)

Home Phone Number_____ _____Work Phone Number_____

Mobile Phone Number_____ Email_____

INSURANCE INFORMATION-

Primary Insurance_____ Secondary Insurance_____

Member #_____ Member #_____

Group #_____ Group #_____

Name of Insured_____ Name of Insured_____

Insured SS#_____ Insured SS#_____

Insured DOB_____ Insured DOB_____

Co-pay Amount_____ Co-pay Amount_____

Employer_____ Employer_____

How were you referred to us?

I hereby authorize to release any medical information necessary to process claims and I agree to assign insurance payment directly to the clinic. I certify that the insurance information supplied is correct and understand I will be responsible for any services not covered by insurance. **I also understand that any co-pay I have with my insurance plan is *due at the time of service*.**

Signature_____ _____Date_____