



Catherine Hylan, MA, LMHC
 Full Circle Counseling, PLLC 360-888-2783
 1155 N State Street, Suite 608; Bellingham, WA 98225

Client Information Form

CONTACT INFORMATION

Legal Name: _____ Date: _____
 Home Address: _____ City: _____
 State: _____ Zip: _____ Date of Birth: _____ Age: _____
 Phone: _____ Okay to leave a message? NO YES Okay to send text? NO YES
 Email: _____ Occupation: _____
 Emergency Contact: _____ Phone: _____
 Relationship to you: _____

IDENTIFYING INFORMATION

Preferred Name: _____ Race/Ethnicity: _____
 Gender: _____ Pronouns: (ex: she/her/hers, he/him/his, they/them/theirs) _____
 Sexual Orientation/ Identity: _____ Religion/ Spiritual Identity: _____
 Anything else you would like me to know regarding your identity: _____

HEALTH INFORMATION

If you answer yes to any of the questions below, please provide any additional information you would like me to know, including dates.

Do you have any current health problems, or have experienced significant health problems in the past?
 NO YES:

Have you ever been hospitalized for psychological reasons? NO YES: _____

Have you ever attempted suicide? NO YES: _____

Have you had serious thoughts of ending your life recently? NO YES: _____

Have you ever intentionally injured yourself? NO YES: _____

Are you currently taking medication (include birth control)? NO YES: _____

Medication: _____ Date Started: _____

Medication: _____ Date Started: _____

Name of Prescriber: _____ Last Visit: _____

REASON FOR SEEKING COUNSELING

What are the main concerns that bring you to counseling? _____

INSURANCE INFORMATION

Primary Insurance (Information found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Relationship to Client:

ID#: _____ Group/Plan#: _____

Secondary Insurance (Information found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Relationship to Client:

ID#: _____ Group/Plan#: _____

I authorize the release of any medical or other information necessary to process this claim through any insurance company. I authorize payment to Catherine Hylan, MA, LMHC, for services rendered as stated on claims submitted to my insurance company. I also understand that it is my responsibility pay for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered, I agree to pay any and all costs of counseling or services provided on my behalf.

Client Signature: _____ Date: _____

AGREEMENT AND CONSENT FOR SERVICES

By signing below, I attest that I have read, understood, and agreed to the Office Policies and Disclosure Statement. I understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Client Signature: _____ Date: _____

Print Name: _____