David Helton, MA, MHP, CMHS, LMFT
18209 State Route 410 E Suit 304 Bonney Lake, WA 98391

CLIENT INFORMATION

Name: _____
Phone: (Cell) _____ (Hm) _____ (Wk) _____
Address: _____City: _____
State: _____Zip: _____ Email: _____
May I mail you at this address? Yes____ No ____ May I email you? Yes ____ No ____
Gender: Male ____ Female ____ Ethnicity: _____ DOB: _____
Employer: _____Occupation:_____
Education (list highest level of education attained): _____
Primary Physician: _____ Phone: _____
List any significant health problems/ medications: _____
_____
Have you seen this type of therapist before? Yes ____ No ____
If yes, when and with whom? _____
Give a brief description of treatment: _____
_____
How were you referred to our office? _____
Who may we thank for referring you? _____

PRIMARY INSURED PERSON'S INFORMATION (where different than above)

Name: _____DOB: _____ Relationship to above: _____
Address: _____
Phone: _____ Employer:_____
Insurance Company: _____ Policy Number: _____
Group Number: _____ Effective Date: _____ # of Sessions: _____

FINANCIALLY RESPONIBLE PERSON'S INFORMATION (if different than above)

Name: _____DOB: _____ Relationship to above: _____
Address: _____
Phone: _____ Employer: _____

**I consent to treatment for the above-named individual and I authorize the release of complete information to my insurance carrier or its intermediaries regarding services here and the assigned benefits to provider for services rendered.*

All information contained above is complete and accurate to the best of my knowledge. I have read and fully understand this agreement.

Client Signature: _____ Date: _____

Legal Guardian and/or insured Signature: _____Date: _____