Commensa Counseling for Wellness; 2596-B East Barnett Road, Medford, OR 97504; 320 E. Main St., Ste. 211, Ashland, OR 97520; Tel: 541-326-0848; www.commensa.org; Email: info@commensa.org

Client Information

A. IDENTIFICATION Date: _____

Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

NOTE: Email may not be a confidential form of communication. Your email will not be shared or solicited. Listing your email here constitutes permission to send protected health information via email.

B. REFERRAL: HOW DID YOU FIND OUT ABOUT COMMENSA COUNSELING? (CIRCLE ONE).

Internet: Google Yahoo Psychology Today Other:_____
Personal contact: Family Friend Co-worker Other:_____

C. RELIGIOUS AND RACIAL/ETHNIC IDENTIFICATION

Current religious orientation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important:_____

D. YOUR MEDICAL CARE

From whom or where do you get your medical care?
Clinic/doctor's name: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. MEDICAL CONDITIONS AND MEDICATIONS:_____

_____

F. YOUR CURRENT EMPLOYER

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions:_____

G. EMERGENCY INFORMATION

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship:_____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

H. INSURANCE, EAP, OR MANAGED CARE BENEFITS (IF APPLICABLE)

1. Name of Primary Insured: _____

   DOB: _____

   Relationship to insured: _____ Employer: _____

2. Insurance Company: _____

   Phone: _____

   This policy is: □ Primary □ Secondary // Do you have another insurance? □ Yes □No
   (Please attach additional sheets for secondary insurance company information)

   Are you covered by the Oregon Health Plan? □ Yes □ No Medicare? □ Yes □ No

   ID#: _____ Group # _____

   Check one of the following: □ Health Insurance □ EAP □ Worker's Compensation □ Auto Insurance

   Address: _____

   City:_____ State: _____ Zip: _____ Insurance Payer

   ID: _____

I have received the Notice of Privacy Practices, and I hereby authorize Jeff Borchers, LPC and appointed billing agent(s) to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits. I further authorize payment of medical benefits to Jeff Borchers, LPC for services provided.

Signed: _____ Date:_____

Relationship to Client: □ Self □ Other: _____

Other Information: _____

For Office Use Only:
Ph _____ *Dt* _____/_____/_____ *Rep* _____ *Eff* _____/_____/_____
Ded _____ *m* _____ □ *Cal* □ *Plan:* _____ *Pd@* _____ *Co* _____ *UCR* _____
V Limit _____/_____ *MN* □ *Auth* □ *PEC Wait* □*Exempt* _____
OOP _____ *Met* _____ *Other:* _____
Eml _____/_____/_____ *Cl pt* _____/_____/_____ @ _____:_____ □*LM* □*Ph*