Healing Heart Ministry
Client Information

Thank you for choosing my office! In order to serve you properly I need the following information filled out completely. Please print. All information will be confidential.

Date_____ Client Name _____
SSN_____-____-_____Birth Date _____
Home Phone_____ Minor Single Married Divorced Widowed
Cell_____
Billing Address_____
City_____ State_____ Zip_____

Employer_____
Work Phone_____
Spouse or parent's name_____Phone_____
Emergency Contact_____Phone_____

Responsible Party

Person responsible for account_____ Relationship_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work phone_____
SSN_____Birth Date_____

Insurance Information (Please fill out completely)

Name of insured_____ Relationship_____
SSN_____ Birth Date_____
Insurance #_____ Employer_____
Insurance Company_____ Group#_____

Secondary Insurance (Please fill out complete)

Name of insured_____Relationship_____
SSN_____ Birth Date_____
Insurance #_____ Employer_____
Insurance Company_____ Group #_____

Primary care physician _____
Phone_____

Consent for the Release of Confidential Information

I _____ authorize Heather Hart, MS, LPC to disclose to
Name of Client/Parent/Guardian

Insurance Company/Insurance Clerk any information required for filing

insurance claims.

I the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.