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				
	Birth Date				
Home Phone	Minor	Single	Married	Divorced	Widowed
Cell		_			
Billing Address					
City		Sta	te	Zip_	
Employer		_			
Work Phone	nme	_			
Spouse or parent's na	ame		Phone_		
Emergency Contact_		Pho	ne		
Responsible Party					
Responsible 1 at ty					
Person responsible for	or account		Rela	ationship	
			1010		
Address					
Address Citv		State		Zip	
City		State	ork phone	Zip	
City Home Phone		Wo	ork phone	e	
City Home Phone SSN Insurance Informat	ion (Please fill out comp	letely)	ork phone Birth	e n Date	
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City Home Phone SSN Insurance Informat Name of insured SSN Insurance # Insurance Company_	ion (Please fill out comp	letely)	ork phoneBirth IBate Employ	e n Date Relationsh yer	ip
City	ion (Please fill out comp	letely) Birth l	ork phone Birth I Date _ Employ	e n Date Relationsh yer roup#	ip
Home PhoneSSN	ion (Please fill out comp	letely) Birth l	ork phone Birth Birth In the second of the	e n Date Relationsh yer roup#	ip
City	ion (Please fill out comp	letely) Birth l te) Relati h Date_	ork phoneBirthI Date Employ Gr onship	e n Date Relationsh yer roup#	ip

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.	
insurance claims.	
I the undersigned, understand that I i	may revoke this consent at any time except to the
extent that action has been taken in r	•