PIMMIT COUNSELING & Wellness Clinic

2235 Cedar Lane
Suite# 102
Vienna, VA 22182
Tel: (703) 556-4888
Fax: (703) 556-7774

# Client Information Form

## Basic

**Last Name: _____First Name: _____Middle Name: _____**

**S.S. #_____ Gender: _____ Age_____ DOB: _____**

**Address: _____ City: _____ State: _____ Zip Code: _____**

**Parent/Guardian Name: _____ Parent/Guardian/E-mail Address: _____**

**Parent/Guardian: Cell Phone: _____ Home Phone: _____ Work Phone: _____**

**Referral Source: _____ Reason/Behaviors of concern: _____**

**Client Availability for Services: _____ Tech Request: _____(gender)**

## Emergency Contact

**Name: _____ Phone Number: _____ Relationship_____**

## Insurance Information

**Primary Insurance: _____ Member ID: _____**

**Policy Holder: _____ S.S. # of Policy Holder: _____**

**Relationship to Policy Holder: _____ D.O.B of Policy Holder: _____**

**Address (if different from above): _____**

**Secondary Insurance: _____ Member ID: _____**

## Assignment of Insurance Benefit

A. I hereby authorize direct payment to Pimmit Counseling & Wellness Clinic for ABA services rendered at this office. I understand that I am financial responsible for any balance not covered by my insurance.
B. In case of no health insurance coverage, payment of services is expected at the time of service.
C. If the cost of the treatment was not paid by the insurance company for any reasons, the client is responsible for the payment and you will be charged by credit card or billed later.
D. Medicaid patients are not responsible for any payment, but they authorize insurance to pay PCWC for their services.

**Type of Credit Card: _____Credit Card Number: _____**

**Exp. Date: _____ Name on Credit Card: _____**

## Authorization to Release Information

I hereby authorize Pimmit Counseling and Wellness Clinic to release medical or incidental information that may be necessary for either medical care or in the processing applications for financial benefits.

**Parent/Guardian Name (if client is under the age of 18): _____**

**Patient/Parent Signature (Guardian): _____Date: _____**