



# The Shaunfield Counseling Center

10601 Grant Road, Suite 114 Houston, Texas 77070  
 Janet Shaunfield (281) 807-4508  
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Please provide the following information to the best of your knowledge. Incomplete/incorrect information can lead to problems in processing your claims and you will be held responsible.

## NEW CLIENT INFORMATION

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ (Please Circle) Gender: M F Marital Status: S M D W Sep Occupation: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ Email: \_\_\_\_\_

Please initial if OK to contact/leave reminders or confidential messages or texts at: Cell: \_\_\_ Home: \_\_\_ Work: \_\_\_ Email: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Referral by: \_\_\_\_\_

Person to contact in case of an emergency/relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Has/Will the client seen/see a psychiatrist or counselor? (please circle) Yes No Previous Diagnosis \_\_\_\_\_

If so, When & Reason: \_\_\_\_\_

Please list all children with ages/birthdays living in home:

Name	Age	Date of Birth

**INSURANCE INFORMATION: PLEASE PRESENT YOUR CARD(S) FOR COPYING.** Primary insurance claims will be filed as a courtesy to the client. However, secondary insurance claims must be paid in full and a receipt will be provided for client to file with secondary insurance company.

### PRIMARY INSURANCE:

Insured's Name: \_\_\_\_\_ Relationship to Client: (please circle): Self Spouse Child Other

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

### SECONDARY INSURANCE:

You are responsible for filing your secondary insurance.

**NOTE:** Some behavioral health insurance companies do not use ID# and only identify clients by the insured's social security number. Clients who do not give this information will have to submit their own claims and pay counselor in full via cash, check, or credit card prior to each session.

### Person Responsible for Payment:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Statement Address: \_\_\_\_\_

*I have completed the above answers and certify this information is true and correct to the best of my knowledge. I agree to notify you of any changes in for the above information.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_