Multicultural Counseling and Research Center
225 South Meramec, Suite 203
St. Louis, MO 63105
314-445-5678

Client Information (Couple/Family)

Client (1) Name _____ D.O.B. _____ Age _____ Sex _____

Client (2) Name _____ D.O.B. _____ Age _____ Sex _____

Address _____ State_____ Zip _____ Home Phone

_____ Work Phone (1)_____(2)_____

Cell Phone (1)_____(2)_____ (Circle the number we can leave message on)

Social Sec # _____ Employer/School/Grade _____

Social Sec # _____ Employer/School/Grade _____

Referral Source_____

Primary Care Physician Name _____ Clinic _____

Ph**one**/Address _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Length of Marriage/Partnership _____ Length of Courtship _____

Times Separated/Divorced – Client (1) _____ Client (2) _____

Religious Preference – Client (1) _____ Client (2) _____

Children: Name Sex Age/ D.O.B. Grade/School

_____

_____

_____

INSURANCE INFORMATION (IF APPLICABLE)

Subscriber _____ D.O.B._____ S.S. # _____

(H) _____ (C) _____

Relationship to Client _____ Employer _____

Address (if difference from client) _____

Insurance Company: _____ Phone: _____

Group/Policy # _____ Identification # _____

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized medical and/or psychological benefits to Multicultural Counseling & Research Center (MCRC) for any services furnished. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services. A photocopy of this assignment is considered as valid as the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for charges whether or not paid by said insurance. If this account is assigned to any attorney for collection and/or suit, I agree to pay your court cost and attorney's fees. I also understand that a 24-hour notice is required for cancelling appointments or I will be charged for the session. I authorize said assignee to release all information necessary to secure payment. I give my consent for this practitioner to render treatment on the above-mentioned patient for mental health services.

Signature _____ Date _____