Counseling Center @ MHA Client Information Form

Client Name: _____ SSN: _____ DOB: _____

I give my permission to be added to MHA's mailing list: ☐ Yes ☐ No

Address: _____
Street City State Zip Code

Race: _____ Gender: ☐ Male ☐ Female

Advanced Directive (do you have a living will?): ☐ Yes ☐ No

May we state Agency name when contacting you via phone or email? ☐ Yes ☐ No

Home Phone:_____ Cell Phone: _____

Work Phone: _____ E-mail: _____

The Counseling Center uses an automated appointment reminder system to verify appointments. Clients who opt out will not receive reminder calls for appointments.
Do you want to receive reminder calls? ☐ Yes ☐ No Which number? _____

Hospital of Choice (circle only one; when selecting other ALL sections must be filled in):

Wesley (316)962-2000;	St. Francis (316)268-5000	St. Joe (316)268-5000
550 N. Hillside St., 67214	929 St. Francis N., 67214	3600 E. Harry St., 67214

Other: _____
Name of Hospital Phone # Address

Parent/Guardian or Financially Responsible Party: (if self write self and move to next highlighted portion)

Name: _____ Relationship to Client: _____

Address: _____ City:_____ Zip: _____

Primary Number:_____ Other Number: _____

If financially responsible: DOB: _____ Social Security Number: _____

Primary Insurance Company

☐ Your information has already been submitted **(Skip to next section if box is checked)**

Name of Company: _____ ID Number: _____

Group Number: _____ Employer: _____

Policy Holder Name:_____ Contact #: _____

DOB: _____ Sex: ☐ Male ☐ Female Social Security #: _____

Secondary Insurance Company

☐ I have no other insurance **(This box must be checked if no secondary company is used)**

Name of Company: _____ ID Number: _____

Group Number: _____ Employer: _____

Policy Holder Name:_____ Contact #: _____

DOB: _____ Sex: Male/Female Social Security #: _____

Over

Emergency Contact **(Required)**

Name: _____ Relationship to Client: _____

Address: _____ City: _____ Zip: _____

Primary Number: _____ Other Number: _____

Primary Care Physician **(Required)**

Name: _____

Address: _____ City: _____ Zip: _____

Office Number: _____ Fax Number: _____

List all parties who will need to have access to your chart information below. If none, leave blank

Case Management (other than MHA)

Last Name: _____ First Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Relationship to Client: _____

Email: _____

School Contact

Last Name: _____ First Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Relationship to Client: _____

Email: _____

Miscellaneous

Last Name: _____ First Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Relationship to Client: _____

Email: _____

The above information is true and accurate. If any information changes, I will notify Counseling Center front office staff.

_____ _____

Signature **Date**