Counseling Center @ MHA
Mental Health Association of South Central Kansas
555 N. Woodlawn, Suite 102
Wichita, KS 67208

Client Name: _____ Hospital of Choice: _____

Home Phone: _____ May we state Agency name? Yes No
Cell Phone: _____ May we state Agency name? Yes No
Work Phone: _____ May we state Agency name? Yes No
E-mail: _____ May we state Agency name? Yes No
I give my permission to be added to our mailing list: ☐Yes ☐No

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? _____

Spouse/Significant Other or Parent:

Name: _____ Relationship to Client: _____

Address: _____ City: _____ Zip: _____

Home Number: _____ Cell Number: _____

Primary Insurance Company

Name of Company: _____ ID Number: _____

Group Number: _____ Employer: _____

Policy Holder Name: _____ Contact #: _____

Address: _____ City: _____ St: _____ Zip: _____

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

Secondary Insurance Company ☐ **I/We have no other insurance**

Name of Company: _____ ID Number: _____

Group Number: _____ Employer: _____

Policy Holder Name: _____ Contact #: _____

Address: _____ City: _____ St: _____ Zip: _____

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

Financially Responsible Person (if other than client):

Name: _____ Relationship to Client: _____

Address: _____ City: _____ Zip: _____

Home Number: _____ Cell Number: _____

DOB: _____ Social Security #: _____

Guardian or Emergency Contact

Name: _____ Relationship to Client: _____

Address: _____ City: _____ Zip: _____

Home Number: _____ Cell Number: _____

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

_____ _____
Signature Date