630 759 6615 Office
630 759 6675 Fax

JEAN MILLER
COUNSELING CENTER, LLC

440 W Boughton Rd. Suite K
Bolngbrook, IL 6044

PERSONAL INFORMATION

Full Name _____ Gender male/female Date: _____

Address _____ City _____ Zip Code_____

Home Phone _____ Cell Phone _____

Birth Date _____ Age _____ Marital Status _____ SSN _____

Name and phone # of responsible party if client is a minor _____

How did you hear about us? (check all that apply)

☐ Church _____ ☐ Insurance Company_____
Church Name

☐ Doctor/Psychiatrist ☐ Friend ☐ Internet Search ☐ Website ☐ Current/Former Client

☐ Psychology Today ☐ FindChristianCounselor.com ☐ Theravive ☐ Other_____

Email Address _____

MEDICAL INFORMATION

Doctor's name and city _____

List current medications _____

Do you have any allergies? _____

Do you have any serious or chronic medical conditions? _____

Who should we contact in case of emergency? _____

_____

INSURANCE INFORMATION (From Insurance Card)

Name of the primary insured person on your policy _____

Primary insured's social security number _____ Primary Insured's Birth Date _____

Primary insured's address _____ City_____ Zip code _____

Primary insured's employer _____ Policy Group # _____

Name of Insurance co. _____ Phone # _____

PROBLEM AREAS

What is the primary reason you are seeking counseling? _____

_____

I acknowledge that I am responsible for all payments to Jean Miller Counseling Center LLC. I further understand that it is my responsibility to bill my insurance company unless otherwise arranged with JMCC and that I am responsible for all co-payments, deductibles, or services denied by your insurance company. I also understand that payment is due at the time of service including any outstanding balance not covered by insurance.

Client Signature/Responsible Party/Parent/Guardian Date