

## STRONGHOLD COUNSELING SERVICES

625 S. Minnesota Ave Suite 201 • Sioux Falls, South Dakota 57104 • Phone (605) 334-7713

Client Name \_\_\_\_\_ Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Alternate phone # \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Stepparent's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

PRIMARY INSURANCE CARRIER			SECONDARY INSURANCE CARRIER		
Company Name	_____		_____		
Address	_____		_____		
City, State, Zip	_____		_____		
Phone #	_____		_____		
Insured's	Name	Relation	Name	Relation	
	DOB	M      F	DOB	M	F
	Employer		Employer		
	ID/Group#		ID/Group#		

**ASSIGNMENT AND RELEASE:** *I hereby agree to pay all co-pays, deductibles, and any amount not covered by my insurance carrier. I understand that all claims are subject to review by my insurance carrier and verification of coverage and benefits made by me or SCS, Inc., are only estimates and SCS, Inc., makes no guarantee of payment by my insurance carrier or health plan. I understand that I am responsible for any amounts not covered by my insurance carrier. I authorize the release of any medical information necessary to process this claim. I authorize payment of benefits to SCS, Inc., unless I have paid my account in full.*

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Client (Parent if Client is Minor)

**MEDICARE AUTHORIZATION:** *I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated above or on the HCFA-1500 form, my signature authorizes release of information to the insurer or agency shown.*

X \_\_\_\_\_ Date \_\_\_\_\_  
 Beneficiary Signature

**SCS, Inc., reserves the right to proceed with collections in the event SCS, Inc., is unable to collect payment from me for services rendered within a reasonable period of time.**

<u>Name of Brothers and Sisters</u>	<u>Age</u>	<u>Name of Stepsiblings</u>	<u>Age</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education – School-Attending \_\_\_\_\_ Grade \_\_\_\_\_

Referred by \_\_\_\_\_ Spiritual Preference \_\_\_\_\_

Previous Counseling \_\_\_\_\_

Church Membership \_\_\_\_\_

Briefly state why you are here \_\_\_\_\_

\_\_\_\_\_

Person to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Information**

Physician \_\_\_\_\_ Medical Problems \_\_\_\_\_

Address \_\_\_\_\_ Serious Illness \_\_\_\_\_

\_\_\_\_\_ (Past or Present) \_\_\_\_\_

Phone \_\_\_\_\_ Most Recent Exam \_\_\_\_\_

Medicine (prescription and non-prescription) \_\_\_\_\_

Unusual Background or Experiences \_\_\_\_\_

**Self-Description**

Physical Condition	Poor	0	1	2	3	4	5	6	7	8	9	10	Athletic
Intelligence	Stupid	0	1	2	3	4	5	6	7	8	9	10	Bright
Physical Appearance	Ugly	0	1	2	3	4	5	6	7	8	9	10	Attractive
Assertiveness	Shy	0	1	2	3	4	5	6	7	8	9	10	Aggressive
Likeability	Disliked	0	1	2	3	4	5	6	7	8	9	10	Well-liked
Self-confidence	Insecure	0	1	2	3	4	5	6	7	8	9	10	Confident
Coping Style	Anxious	0	1	2	3	4	5	6	7	8	9	10	Relaxed
Personal Worth	Bad	0	1	2	3	4	5	6	7	8	9	10	Good

List some particularly positive things about yourself (assets, talents, etc.) \_\_\_\_\_

\_\_\_\_\_

List some particularly negative things about yourself (faults, deficiencies, etc.) \_\_\_\_\_

\_\_\_\_\_

**Financial Agreement**

Name of person responsible for payment \_\_\_\_\_

Relationship to student \_\_\_\_\_

Are there any unusual financial considerations? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain \_\_\_\_\_

Social security number of financially responsible party (parties)

Father \_\_\_\_\_ Mother \_\_\_\_\_

Other \_\_\_\_\_

(Social security#)

(Relationship)