Synchronicity Counseling Solutions

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New Client Information

Please print clearly.

Date of Birth: / /	**SSN:** - -	**Gender:**
First Name:	**Middle Initial:**	**Last Name:**
Street Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**OK to Leave Messages?** Yes No	
Work Phone:	**OK to Leave Messages?** Yes No	
Mobile Phone:	**OK to Leave Messages?** Yes No	
E-mail:	**OK to Send Messages?** Yes No	
Emergency Contact:	**Phone:**	
Referred by:		
Is it ok to thank the person who referred you (without mentioning your name)? Yes No		

Complete the following information only if you wish to have sessions submitted to your health insurance carrier.

Insurance Company:		
ID#:	**Group#:**	
Primary Insured (if not you):		
Primary Insured Date of Birth:		
Is policy through an employer? Yes No	**Which employer:**	
Deductible:	**Co-Pay:**	**Co-Insurance %:**