



Dina Yerex, LPC, CADC III

17356 Strauss Avenue
Sandy, Oregon 97055

406 NE 4th Street
Gresham, Oregon 97030

Name: _____ Today's Date: _____

Date of Birth: _____

Gender: _____

How did you hear about my counseling services? _____

Home Address: _____ City, State, Zip: _____

Mailing address (if different): _____

Are there any limits on sending mail to the above address(es)? Yes No If "yes", explain: _____

Cell Phone: _____

OK to leave messages? Yes No

Home Phone: _____

OK to leave messages? Yes No

Work Phone: _____

OK to leave messages? Yes No

Email address: _____

Is it okay to use text messages to communicate with you? Yes No

Is it okay to use e-mail to communicate with you? Yes No

Employer: _____

Occupation: _____

Marital Status: _____

Spouse/Partner's Name: _____

Emergency Contact Name: _____

Telephone: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Primary Care Physician: _____

Telephone: _____ Practice/Clinic Name: _____

Address, City, State, Zip: _____

Insurance Information:

Insurer: _____

Phone: _____

Client's ID: _____

Group #: _____

Behavioral Health Subcontractor (If Applicable): _____

Policy Holder's Name (If Different from Client): _____

Policy Holder's ID: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____

Other insurance coverage? Yes No If "yes", please list information on separate sheet

Release: I authorize *Dina Yerex, LPC, CADC III*, to release any medical information necessary to provide treatment and process my claim(s). I hereby authorize and assign my insurance benefits to be paid directly to *Dina Yerex, LPC, CADC III*. I understand that I am financially responsible for any co-pays, co-insurance, deductibles, and non-covered services not paid by my insurance or other third-party payer. I permit a copy of this authorization to be used in place of original

Client Signature

Printed Name

Date