

Counseling Solutions
8820 Commerce Loop Drive
Columbus, OH 43240
614-880-9800
Fax: 614-880-9802

Date _____
Therapist _____
Diagnosis _____

Name _____
Address _____
City, State, Zip _____
Home Phone _____ Work _____ Cell _____
Date of Birth _____
Marital Status _____ Years Married _____ Years Divorced _____ Divorced what year _____
Spouses Name _____
Spouses Date of Birth _____



Occupation _____ Last Grade Completed _____
Employer _____ Phone Number _____
Spouses Employer _____ Phone Number _____
Primary Insurance _____
Primary Holder of Insurance _____ Date of Birth _____
Group Name _____ Group Number _____
ID Number _____ Provider Phone Number _____
Co-Pay Amount _____

*****24 hours notice is required to cancel an appointment without being charged. Failure to do so will mean that you forfeit any pre-payment for a scheduled session and/or will make you accountable for payment in full for the canceled session.**

Signature _____

Please make checks payable to: Counseling Solutions