Inner Guidance Counseling Center, LLC
888 West Big Beaver Rd. Suite 780, Troy, MI 48084

_____ _____ _____
Patient's Name Social Security Number Date of Birth

_____
Address City, State, Zip Code

_____ _____ _____
Telephone (Home) (Cell) (Work)

If Patient is a Minor:

_____
Name of Parent or Legal Guardian

_____ _____ _____
Phone (Home) (Cell) (Work)

_____ _____
Primary Insurance Phone

_____ _____
Policy Holder's Name Date of Birth

_____
Policy Holder's Address

_____
Policy Number Group Number

_____
Social Security Number of Insured

I, _____, hereby apply for treatment at Inner Guidance Counseling Center, LLC**. I understand that all co-payments are to be paid at the time of service. A no show fee of $75.00 will be charged for appointments not cancelled 24 hours in advance.** I hereby authorized release of my patient records to my insurance company(s) for the purpose of authorization of services and payment of the bill.

_____ _____
Patient's Signature or Parent/Legal Guardian of Patient Date

_____ _____
Witness Date

DX: _____

Revised 10/7/19