Bren Shantz
5270 Northland Dr NE, Ste B
(616) 439-1866
brenshantz@outlook.com
UnityCounselingGR.com

Registration Form

Primary Client Information:

Full Legal Name:		**Date of Birth:**	**Legal Gender:**
		/ /	☐ Man ☐ Woman
Preferred / Nickname:	**Marital Status:**		
	☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed		
Employment Status:	**Ethnicity:**		**Sexual Orientation**:
☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed ☐ Student ☐ Retired ☐ Disabled	☐ African American or Black ☐ American Indian or Alaskan Native ☐ Asian American or Asian ☐ Hispanic or Latino/a ☐ Northern European or White ☐ Other:		☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning ☐ Other:
Physical address:			**Email address: (Schedule?)**
			(☐ Yes)
Home Phone: (Leave Msg.?)	**Cell Phone: (Leave Msg.?)**		**Work Phone: (Leave Msg.?)**
(☐ Yes)	**(☐ Yes)**		**(☐ Yes)**

Responsible Party (For Minor Client ONLY):

Responsible Party Name:		**Date of Birth:**	**Legal Gender:**
		/ /	☐ Man ☐ Woman
Physical address:			**Email address: (Schedule?)**
			(☐ Yes)
Home Phone: (Leave Msg.?)	**Cell Phone: (Leave Msg.?)**		**Work Phone: (Leave Msg.?)**
(☐ Yes)	**(☐ Yes)**		**(☐ Yes)**

Insurance Information:

Primary Insurance Name:	**Policy #:**	**Group #:**
Policy Holder Name:	**Date of Birth:**	**Relationship to Client:**
	/ /	☐ Self ☐ Spouse ☐ Dependent
Secondary Insurance Name:	**Policy #:**	**Group #:**
Policy Holder Name:	**Date of Birth:**	**Relationship to Client:**
	/ /	☐ Self ☐ Spouse ☐ Dependent

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Please check any of the following as they apply to you:

In the PAST 2 WEEKS, I have experienced:	**In the COURSE OF MY LIFE, I have experienced:**
☐ Relationship conflict (family, friend, partner, etc.)	☐ Relationship conflict (family, friend, partner, etc.)
☐ Social avoidance or withdrawal	☐ Social avoidance or withdrawal
☐ Sleep disturbance	☐ Sleep disturbance
☐ Problems with eating, weight, or body image	☐ Problems with eating, weight, or body image
☐ Anxiety	☐ Anxiety
☐ Perfectionism	☐ Perfectionism
☐ Phobias or extreme fears	☐ Phobias or extreme fears
☐ Obsessive thinking	☐ Obsessive thinking
☐ Compulsive behaviors (checking, cleanliness, etc.)	☐ Compulsive behaviors (checking, cleanliness, etc.)
☐ Agitation or restlessness	☐ Agitation or restlessness
☐ Increased activity level or over exercise	☐ Increased activity level or over exercise
☐ Depression	☐ Depression
☐ Decreased interest or pleasure	☐ Decreased interest or pleasure
☐ Fatigue or low energy	☐ Fatigue or low energy
☐ Physical health problems	☐ Physical health problems
☐ Grief or loss	☐ Grief or loss
☐ Sexual contact with you without your consent	☐ Sexual contact with you without your consent
☐ Verbal or emotional abuse	☐ Verbal or emotional abuse
☐ Physical assault	☐ Physical assault
☐ Race or ethnicity-based abuse or discrimination	☐ Race or ethnicity-based abuse or discrimination
☐ Sexuality or gender-based abuse or discrimination	☐ Sexuality or gender-based abuse or discrimination
☐ Other traumatic event(s)	☐ Other traumatic event(s)
☐ Auditory or visual hallucinations	☐ Auditory or visual hallucinations
☐ Alcohol abuse	☐ Alcohol abuse
☐ Marijuana abuse	☐ Marijuana abuse
☐ Prescription medication abuse	☐ Prescription medication abuse
☐ Other drug abuse	☐ Other drug abuse
☐ Other addictive behavior (gambling, porn, etc.)	☐ Other addictive behavior (gambling, porn, etc.)
☐ Self-injurious behavior	☐ Self-injurious behavior
☐ Suicidal thoughts	☐ Suicidal thoughts
☐ Suicide attempt	☐ Suicide attempt
☐ Homicidal thoughts or violence toward others	☐ Homicidal thoughts or violence toward others
☐ Legal problems, arrest, or jail time	☐ Legal problems, arrest, or jail time

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Client Full Legal Name:	Date of Birth:
	/ /
Parent / Legal Guardian Name:	**Relationship to Client:**
Parent / Legal Guardian Name:	**Relationship to Client:**

Insurance Billing

I/we authorize Unity Counseling, LLC to release any medical information to its billing company for paper and/or electronic billing of the insurance company. While I/we authorize the insurance company to assign benefits to Unity Counseling, LLC, I/we understand that I/we am/are responsible for payment for services rendered by Unity Counseling, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I/we agree to notify the Unity Counseling, LLC immediately whenever I/we have changes in my health plan coverage.

Account Responsibility

I/we am/are responsible for payment to Unity Counseling, LLC for all services rendered, due at the time of the visit. I/we also understand that if I/we suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, the Unity Counseling, LLC reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names the Unity Counseling, LLC as a creditor in any bankruptcy filing.

Informed Consent & Notice of Privacy Practices

I/we am/are consenting to treatment and have received and understand the contents of the Policies, including the Notice of Privacy Practices (HIPAA). My/our signature(s) below indicates that I/we have been provided a copy of, and that I fully understand & agree to all the terms and conditions of the Policies. If I/we have had questions, the information has been explained and/or summarized for me.

Signature (Client or Legal Guardian):	Date:
	/ /
Signature (Legal Guardian):	**Date**:
	/ /