

### ***3 Star Ranch Equine Assisted Psychotherapy for the Whole Family, PC***

Anita J. Walraven, MA, LMFT #MFC 40657

Licensed Marriage & Family Therapist

#### **CONFIDENTIAL CLIENT INFORMATION**

<b>Client's Name:</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Parent or Spouse Name: (for insurance purposes)</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Guardian or Sponsor:</b>	<b>Email Address:</b>	
<b>Client's Address:</b>	<b>Home Telephone:</b>	
	<b>Work Telephone:</b>	
	<b>Cell Telephone :</b>	
<i>Please circle if it is okay to call and leave messages at:      Home                      Work                      Cell</i>		

#### **Family Information**

<b>Marital Status:</b>	<b>Single</b>	<b>Married (Date)</b>	<b>Divorced (Date)</b>	<b>Widow (Date)</b>
<b>Please list all children (or siblings if a child) below:</b>				
<b>Children:</b>	<b>Age</b>	<b>Gender</b>	<b>Biological Parents (if step/half siblings)</b>	<b>School and Grade</b>

#### **Insurance Information**

<b>Insurance Company:</b>	<b>Address:</b>	<b>Telephone Number:</b>
<b>Subscriber's Name:</b>	<b>ID#:</b>	<b>Group Number:</b>
	<b>Date of Birth:</b>	

#### **Employment Information**

<b>Employer:</b>	<b>Address:</b>	<b>Telephone No.</b>
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#### **Other Information**

<b>Referring Person:</b>
<b>What do you hope to change or accomplish by seeking help at this time:</b>

I hereby authorize insurance or any other organization payment be paid directly to Anita Shumway Walraven, MA, LMF (*3 Star Ranch*) for counseling services. I understand that the fee for these services is \$100 per session unless otherwise arranged. Further I also understand that I am financially responsible for these services.

SIGNATURE OF CLIENT: \_\_\_\_\_ DATE: \_\_\_\_\_