DONARSKI CENTER *for* MENTAL HEALTH COUNSELING

2025 INFORMATION UPDATE AND AUTHORIZATION (ADULT)

DEMOGRAPHIC INFORMATION

Name: First _____ Middle _____ Last _____

Address: _____ City/State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____ Work: _____

Email Address: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE (If we copied your insurance card(s), skip to the signature portion at the bottom of this page)

Insurance Provider: _____ ID# _____

Group/Plan: _____ Policy Holder's Name: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Phone: _____

Address on back of card: _____

SECONDARY INSURANCE

Insurance Provider: _____ ID# _____

Group/Plan: _____ Policy Holder's Name: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Phone: _____

Address on back of card: _____

I understand that I am responsible for my fees. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I will honor contractual agreements made with managed health care companies which stipulate specific reimbursement restrictions.

I hereby consent to treatment by a specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance prior to a decision to end therapy.

I hereby authorize the release of necessary medical information for insurance reimbursement purposes. Furthermore, I authorize the payment of medical benefits to the Donarski Center for Mental Health Counseling, LLC/Edwin R. Vergara MA, LPC (provider services).

I have read the following documents: Informed Consent for Treatment, Health Insurance Portability and Accountability Act (HIPAA) Notification, Payment and Insurance Agreement which are available at www.DonarskiCenter.com and upon request in the Donarski Center office. Signing this form indicates my agreement and consent with these notifications and authorizations as well as my agreement that Donarski Center may contact me with detailed information regarding appointments, treatment, and billing via methods I shared on this document or on intake forms.

Client Signature: _____ **Date:** _____