



# DONARSKI CENTER *for* MENTAL HEALTH COUNSELING

## 2026 INFORMATION UPDATE AND AUTHORIZATION (ADULT)

### **DEMOGRAPHIC INFORMATION**

Client Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_ Birthday \_\_\_\_\_

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 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](http://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:** \_\_\_\_\_