

# School of Allied Health Professions Child & Family Counseling Clinic

(504) 556-3451 phone

(504) 556-7540 fax [cfcc@lsuhsc.edu](mailto:cfcc@lsuhsc.edu)

**New Patient/Returning Patient Contact Form**

Thank you for your interest in seeking services with the LSUHSC Child & Family Counseling Clinic. To initiate a service request please complete this form and email it back to our office at [cfcc@lsuhsc.edu](mailto:cfcc@lsuhsc.edu) along with the **front and back of your insurance card and picture ID**. Once the completed form is received, we will verify your insurance coverage. If approved, you will be notified of clinician and appointment availability. **Submission of this form does not guarantee services will be rendered.** Clinicians at the LSUHSC Child & Family Counseling Clinic provide services within the scope of their practices.

**Failure to complete this form in its entirety may result in a delay of scheduling services.**

Today’s Date: Patient’s Name:

Patient’s DOB: Patient’s School/Grade:

Name Legal Guardian #1: Phone # Legal Guardian #1:

Name Legal Guardian #2: Phone # Legal Guardian #2:

Email Legal Guardian #1: Email Legal Guardian #2:

What services are you seeking?

Counseling/Therapy Evaluation/Testing Both Unsure

Primary Language Spoken: Primary Care Physician :

Primary Care Physician Phone #: Emergency Contact & #:

Referred by (Name): Relationship to Patient :

Presenting Issue(s):

How long have the issue(s) been presenting:

Patient’s Name:

Frequency (how often) of presenting issue(s):

Intensity of presenting issue(s): Low

Medium

High

Environment in which presenting issue(s) are presented: Home School Social Other Has the patient received any of these professional services in the past?

Therapy Evaluation Psychology \_ Psychiatry Occupational Therapy ABA Therapy

Department of Children & Family Services (please explain):

Does the patient have a current diagnosis (if yes, report the diagnosis(es): Evaluator’s Contact Name: Email:

Custody Information:

Any other relevant information:

Patient ability to attend in person/telehealth sessions:

Monday Tuesday Wednesday \_ Thursday

Times available:

**Insurance Information**

Responsible Person’s Name: DOB:

Phone #: Email:

Address:

Insurance Company: Insurance Address:

Insurance Policy #: