School of Allied Health Professions
Child & Family Counseling Clinic
(504) 556-3451 phone
(504) 556-7540 fax 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 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: _____ Name Legal Guardian #2: _____

Phone # Legal Guardian #1: _____ 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 Policy #: _____

Insurance Address:

_____

_____