

**Terri Clinton Dichiser, JD, MA, LCPC, NCC,  
Take Charge Inc.**

14700 Metcalf Avenue, Suite 100, Overland Park, KS 66223  
(913) 239-TALK (8255)

**Client Information:**

Today's Date \_\_\_\_\_ Employer \_\_\_\_\_  
Name \_\_\_\_\_ Employer's Complete Address: \_\_\_\_\_  
          First        M.I.        Last  
SS# \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Marital Status: Married Single Divorced Widowed Separated  
Sex: Male Female Spouse's Name \_\_\_\_\_  
E-mail address \_\_\_\_\_

**Responsible Party (if other than Client):**

Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

**Insurance Information (If insurance card has been submitted, skip to employer section):**

Full Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Complete Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Effective Date \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Mental Health Insurance Phone # \_\_\_\_\_  
**Name of Employer** \_\_\_\_\_ Employer Phone # \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Do you have any other insurance?** Yes No (If yes, please provide: Insured's  
Name \_\_\_\_\_ Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_

I hereby authorize Terri Clinton Dichiser LCPC, Take Charge Inc., to release any information acquired in the course of my treatment or examination to my insurance company for billing purposes only. \_\_\_\_\_

I understand even though Terri Clinton Dichiser is an out of network provider, benefits could be paid directly to Take Charge Inc. I understand if payment is made to Take Charge, Inc., I will be contacted for action regarding such payment(s). \_\_\_\_\_

I understand that I am fully responsible for all services and charges at the time services are rendered, even if I have benefits through insurance. I authorize treatment by this office. \_\_\_\_\_