New Leaf Wellness Center
10600 Montwood #123
Ph. (915) 313 - 4114
newleafwc.com

Today's Date:

Client Information		
Name:	Age:	Date of Birth:
Address:	City & Zip Code:	
Primary phone:	Secondary phone:	
Email:	Social Security:	
Medicaid or Private Insurance info:		

Responsible Person *(Example, parent of minor child)*	
Name:	Date of Birth:
Relationship to Client:	Social Security:
Email:	

Reason for Visit
How did you hear about New Leaf?

Have you visited another mental health provider within the last 6 months?	
Yes	No
If so, who?	

I am authorizing New Leaf Wellness Center and their personnel to conduct an evaluation and assessment of needs based on my results. If mental health counselling is needed and I am accepted as a patient, I release all information necessary to verify eligibility of mental health benefits if I am using my insurance to process payment. My signature on this form does not guarantee acceptance as a patient or that my insurance will process payment in full. I understand that insurance matters are between the insured patient and the Insurance Company. Therefore, any claims or fees not paid by my insurance company are the responsibility of myself, my legal guardian, or the person assuming responsibility. Any fees not collected or paid regardless of reason or fault, can be forwarded to a collection agency to process collection of those unpaid fees if I fail to pay those fees.

If I am here for court or probation ordered classes, I understand the classes are not medical treatment and do not follow medical guidelines & protocol.

Signature Print Name Date

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