**MKC Counseling, LLC**

**Evaluation Appointment Request Form**

**Part 1 — Basic Information**

*Please email both completed forms (basic information and insurance information) to Marcia@MKC-Services.com. Once both forms are received, you will be sent a link to the online scheduler.*

Client Name: _____ Date of Birth (MM/DD/YY): _____

Is client a minor? ☐ Yes ☐ No

Does the client have a guardian? ☐ Yes ☐ No

Is the client in foster care? ☐ Yes ☐ No

**For Clients in Foster Care:**

Case worker name: _____

Case worker Phone: _____

Case worker Email: _____

**Information Needed For All Clients**

Parent/Foster Parent/Caregiver name: _____

Parent/Foster Parent/Caregiver address (with city and zip code):

_____

Parent/Foster Parent/Caregiver Phone: _____

Parent/Foster Parent/Caregiver Email: _____

**What is your main concern or purpose for requesting an evaluation?**

☐ Autism

☐ ADHD

☐ School Problems

☐ Clarification of Diagnosis and Treatment recommendations

☐ Other (please explain): _____

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**Part 2 — Insurance Information**

**Please initial next to each statement to acknowledge them.**

____ Failure to disclose primary insurance will result in a full cash charge. Do not report a secondary insurance without a primary insurance!

____ MKC Counseling, LLC accepts Blue Cross Blue Shield of Kansas, Aetna, all Medicaid plans, and Medicare. If your plan is not listed, you are responsible for calling the number on the back of your insurance card to see if we are a provider. If not, you may pay out of pocket for services.

____ You are responsible for calling your insurance plan using the number on the back of your card to check if pre-authorization is required for us to bill services through insurance. Not doing so may result in delayed scheduling.

**Primary Insurance Information**

Who is the policyholder of the primary insurance? ☐ Client ☐ Parent

Primary insured's name: _____

Primary insured's date of birth (MM/DD/YY): _____

Primary insured's address (with city and zip code):

_____

Primary insured's SSN: _____

Primary insured's employer: _____

Primary insurance plan: _____

Primary insurance member ID: _____

Primary insurance copay: _____

Primary insurance deductible: _____

Does your plan require pre-authorization for us to bill services? ☐ Yes ☐ No

**Secondary Insurance Information (If Applicable)**

Who is the policyholder of the secondary insurance? ☐ Client ☐ Parent

Secondary insured's name: _____

Secondary insured's date of birth (MM/DD/YY): _____

Secondary insured's address (with city and zip code):

_____

Secondary insured's SSN: _____

Secondary insured's employer: _____

Secondary insurance plan: _____

Secondary insurance member ID: _____