



RIVERSTONE
COUNSELING PROGRAM

Please bring completed form to your first counseling appointment, or email to hello@riverstonecounseling.org

Please note: email must be encrypted to be secure

Client Contact Information

Name: _____ Date: _____ Gender: _____ Sex at birth: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Birth Date: _____ Age: _____

Mother's Maiden Name: _____

Phone #: _____ E-mail: _____ Other: _____

Best time / day to be reached: _____ OK to leave a message? Yes No

How would you like appointment reminders? Text Email Voicemail Spectrum Drop-in Center
(please choose one)

Emergency Contact: _____
Name Phone Number Relationship

Insurance Information

Do you have Green Mountain Medicaid? Yes No If yes, ID#: _____

and please skip the next question and move to the back of the form.

If no, do you have other insurance? Yes No

If yes:

Insurance company	
Insurance ID # & Group #	
Subscriber name	
Subscriber date of birth	
Subscriber address	
Client's relationship to subscriber	
MH/SA provider phone #	

Is subscriber responsible for payments? Yes No

go to back →

Demographic Questions

Race:	Ethnicity:
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Non-Hispanic/Non-Latino
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Decline to answer/Don't know
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	
<input type="checkbox"/> White	Primary Language spoken in your home: _____
<input type="checkbox"/> Biracial	Preferred Language: _____
<input type="checkbox"/> Other _____	Ability Accommodations: _____
<input type="checkbox"/> Decline to answer/Don't know	

For Office Use Only

Insurance card scanned on both sides to mhutter@spectrumvt.org? Yes No

ADAP grant client? Yes No

Co-pay or payment owed? Yes No If yes, agreed upon amount? _____

Consent for text/email reminders? Yes No

Release for guarantor? Yes No

Client Medicaid? SUD MH

Other Information: _____

