



**To schedule an appointment, the below information is needed:**

**To assist with collaborative care, and if you choose to, please request, sign, and submit ROIs (Release Of Information) from the locations of your previous therapists/mental health care teams. and any pertinent medical care. Thank you for helping your team make your mental health care fluid and comprehensive.**

Legal Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Permitted to leave detailed voicemails and detailed text messages: \_\_\_\_\_ Yes. \_\_\_\_\_ No

Insurance: Company: \_\_\_\_\_ ID: \_\_\_\_\_

Choosing Private Pay: \_\_\_\_\_ Yes \_\_\_\_\_ No, using above insurance information

How did you hear about Firefly Counseling NC: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_

Contact information of EC: (Phone): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Once this form is completed and submitted, you will be contacted for additional information, including payment information to assist in filing insurance and simplifying paperwork for the initial session. Thank you for your assistance with this.**

Current FC Hours: Hours vary depending on day of week.

Monday	9am-12pm	Thursday	9am-4pm
Tuesday	9am-5pm	Friday	8am-12pm
Wednesday	9am-6pm		