

Healing Steps Family Therapy, LLC

Group Practice | Stephen M. Stepanovich, MS, LMFT, CEO

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CLIENT COVER SHEET

Date: _____ Therapist: _____

Name of Client	Preferred Name / Pronouns	Date of Birth	Age
Cell Phone	Other Phone	Email	OK to leave voicemail? Y / N
Street Address	City	State	Zip Code
Preferred contact: ☐ Call ☐ Text ☐ Email (see communication consent)	Gender	Occupation	Education/Degree
Place of Employment	Nearest Relative	In case of emergency, notify (name / relationship / phone):	

Type of service requested

☐ Individual ☐ Couples (private pay starting 1/1/2027; current insured couples 4/1/2027) ☐ Family (private pay starting 1/1/2027) ☐ Child/Teen ☐ In-Home Family Treatment

Payment method

☐ Private pay / self-pay (you will receive a Good Faith Estimate) ☐ Insurance (individual therapy only)

Insurance company	Member ID	Group #
Policyholder name	Policyholder DOB	Relationship to client

Accepted plans: Cigna, Anthem Blue Cross, Aetna, United (UnitedHealthcare/Optum), and Carelon Behavioral Health. Couples therapy is not billed to insurance starting January 1, 2027 (current insured couples: April 1, 2027, after a 90-day grace period). Family therapy is private pay starting January 1, 2027. A card on file is required for all clients.

Marital / Relationship Status: ☐ Never Married ☐ Married ☐ Living w/ Partner ☐ Divorced ☐ Widowed ☐ Separated If married/partnered, how long? _____		
Referral Source – Agency or Individual	Other Agencies Involved	
Primary Care Physician	Religion / Spiritual practice (optional)	
Name of School (if attending)	Grade	☐ Special Educ. ☐ Gifted Educ. ☐ 504 Plan ☐ IEP ☐ ESL

Family Members (Spouse/partner, children)

Name	Age/DOB	Relationship	Grade/Occupation	Living in Home Y/N

Client's Family of Origin (Mother, father, brothers, sisters)

Name	Age	Relationship	Grade/Occupation	Living in Home Y/N

Medications – Please list current medications of the person for whom you are requesting therapy (child, teen, adult)

Previous Therapy Treatment (With whom? How long?)