2005 Asbury Rd
Dubuque, Iowa 52001
PH: 563-583-7357

Please mark which location you are interested in starting services with and fax or mail your application directly to that location. Allow 3 business days for our office to confirm and verify insurance eligibility. It is our goal to ensure you are aware of any cost to you.

All locations provide counseling. A (♦) denotes medication management services are available as well.

Dubuque Locations

☐ **Asbury MHC**
2005 Asbury Rd.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026

☐ **Crescent MHC**
1789 Elm St.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026

☐ **Mercy MHC ♦**
PAP Bldg.
200 Mercy Dr., Suite 200
Dubuque, IA 52001
PH: 563-582-0145
Fax: 1-888-526-5456

☐ **Solutions MHC ♦ *****
5900 Saratoga Plaza
Dubuque, IA 52002
PH: 563-231-3521
Fax: 563-231-3522

☐ **Unity Point Dubuque MHC**
4170 Pennsylvania Ave
Dubuque, IA 52002
PH: 563-583-7357
Fax: 563-583-7026

Northeast Locations

☐ **Maquoketa MHC ♦**
117 S. Olive St.
Maquoketa, IA 52060
PH: 563-652-4958
Fax: 563-652-2418

☐ **Unity Point Cascade MHC**
610 2nd Ave NE
Cascade, IA 52033
PH: 563-583-7357
Fax: 563-583-7026

☐ **Unity Point Peosta MHC**
8456 Peosta Commercial Ct.
Peosta, IA 52068
PH: 563-583-7357
Fax: 563-583-7026

☐ **Jones MHC ♦**
818 W 1st St., Suite 100
Monticello, IA 52310
PH: 319-844-1119
Fax: 319-844-1121

Southeast Locations

☐ **Washington MHC ♦**
2175 Lexington Blvd, Bldg. 2
Washington, IA 52353
PH: 319-653-6161
Fax: 319-863-1311

☐ **Henry MHC ♦**
106 N Jackson St.
Mt Pleasant, IA 52641
PH: 319-385-7177
Fax: 319-385-9567

☐ **Louisa MHC ♦**
220 N Second St.
Wapello, IA 52653
PH: 319-527-4455
Fax: 319-527-4458

☐ **Keokuk MHC**
23019 Hwy 149
Sigourney, IA 52591
PH: 319-653-6161
Fax: 319-863-1311

☐ I would like counseling services.

☐ I would like medication management services.

If you need to speak to someone before you are contacted please utilize our Crisis Recovery Team at 1-855-800-1239 OR call 9-1-1.

Thank you!

Hillcrest Family Services

*********Not all insurances are accepted at this location*

☐ New ☐ Update

Hillcrest Family Services
Demographic Form

Client Status: ○ **Pre-Registered** ○ **Admit**

Client Legal Name:_____
(Last) *(First)* *(MI)* *(Suffix)*

Alias/Maiden Name:_____
(Last) *(First)* *(MI)*

Client Address:_____

City/State/Zip:_____ **County:**_____

Mailing Address *(if different)*:_____

City/State/Zip:_____

OK to send mail? ○ **Yes** ○ **No** ○ **Unknown**

Primary Phone #:_____ ○ Home ○ Cell

Preferred means of communication (Appointment Reminders): ○ **Phone call** ○ **Text** ○ **None**

Work Phone #:_____

Other Phone #:_____ ○ Home ○ Cell

Special Calling Instructions:_____

Email Address:_____ **Ok to send e-mail?** ○ **Yes** ○ **No**

Client Legal Status: ○ **Adult** ○ **Adult with Guardian** ○ **Minor with Guardian** ○ **Emancipated Minor**

Legal Guardian Name:_____ **Relationship to Client:**_____

Address:_____

City/State/Zip:_____ **Phone:**_____

Does Client have an Emergency Contact? ○ **Yes** ○ **No**

Emergency Contact Name:_____ **Relationship to Client:**_____

Address:_____

City/State/Zip:_____ **Phone:**_____

Date of Birth:_____ **Gender:** ○ **Male** ○ **Female** ○ **Transgender**

Social Security #:_____ Reason why SS# not provided:_____

Race:_____ **Marital Status:**_____ **Ethnicity:**_____

Language:_____ **Religion:**_____ **Is this person in special education:** ○ **Yes** ○ **No**

Last Grade Completed:_____ **School:**_____

Interpreter needed? ○ **Yes** ○ **No** **School District:**_____

Employment Status:_____ **Household Income:**_____

Living Arrangement:_____ **Household Composition:**_____
(Foster care, group home, etc.) *(Single adult, significant other, etc.)*

Does Client have an Advance Directive? ○ **Yes** ○ **No**

Smoking Status: ○ Current, everday smoker ○ Current, some day smoker ○ Former smoker ○ Never smoker ○ Smoker, current status unknown ○ Unknown if ever smoked

Client Name:________________________________ **SS#:**________________________ **DOB:**________________

Relationship Information *(Household Members Detail)*

Relationship:________________________________ If other, please specify:______________________________

Name:______________________________________ **DOB:**________________ **Gender:**_____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:__________________________________ **Work Phone:**________________________________

Relationship:________________________________ If other, please specify:______________________________

Name:______________________________________ **DOB:**________________ **Gender:**_____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:__________________________________ **Work Phone:**________________________________

Relationship:________________________________ If other, please specify:______________________________

Name:______________________________________ **DOB:**________________ **Gender:**_____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:__________________________________ **Work Phone:**________________________________

Relationship:________________________________ If other, please specify:______________________________

Name:______________________________________ **DOB:**________________ **Gender:**_____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:__________________________________ **Work Phone:**________________________________

Referral Source:___________________________ **Referral Information:**__________________________________

Presenting Problem:

Scheduling Requirements:____

Did the Client Provide the Information? ○ **Yes** ○ **No**

Name of person providing information *(if not the client)*:____

Relationship to Client:________________________________ **Phone Number:**______________________________

Name & Employee ID of Person Obtaining Information:

____ ____________________ ______________

Name Employee ID Date Time

Name & Employee ID of Person Entering Information:

____ ____________________ ______________

Name Employee ID Date Time

Hillcrest Family Services
Client Insurance Form

Client Name:_____ **Date:**_____

Primary Insurance:

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

Secondary Insurance: *(If applicable)*

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical and/or government benefits either to myself or to the party who accepts assignment below.

Signed:_____ **Date:**_____