

CLIENT INFORMATION

TODAY'S DATE: _____
CLIENT NAME: _____ AGE: _____ DOB: _____
ADDRESS: _____ CITY: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____ SS#: _____
EMPLOYER: _____ WORK PHONE: _____
SPOUSE: _____ CELL PHONE: _____ WORK PHONE: _____
PARENTS (if minor): _____
EMAIL ADDRESS: _____

If you have medical insurance that covers psychotherapy, upon request, we will gladly provide you with an invoice stating the dates of service. However, it is the patient's responsibility to submit the invoice to the insurance company for reimbursement, if applicable. Payment in full is due at the time of service.

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____
(Name) (Phone) (Relationship)

LIST ALL FAMILY MEMBERS: (Use back if necessary)

<u>NAME</u>	<u>BIRTHDATE</u>	<u>AGE</u>	<u>SEX</u>	<u>RELATIONSHIP</u>	<u>AT HOME</u>	
_____	_____	_____	_____	_____	Y	N
_____	_____	_____	_____	_____	Y	N
_____	_____	_____	_____	_____	Y	N
_____	_____	_____	_____	_____	Y	N

WHO REFERRED YOU TO THIS OFFICE? _____

FAMILY PHYSICIAN: _____

PLEASE GIVE A BRIEF DESCRIPTION OF THE REASON(S) WHY YOU ARE HERE: _____

PREVIOUS THERAPY: Yes ___ No ___ IF SO, WITH WHOM/REASON/DATES: _____

I authorize the release of any information necessary to process any/all insurance claims yes, no. I acknowledge that I am financially responsible for all charges regardless of my insurance coverage.

SIGNATURE OF CLIENT/RESPONSIBLE PARTY

PRINTED NAME