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)

NAME	BIRTHDATE	AGE	SEX	RELATIONSHIP	AT HOME
_____	_____	____	____	_____	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**