PATIENT INFORMATION

Please print and complete all information:

Client Name: _____ Date: _____

(if client is a child, under age 18) Parent Name: _____

Client Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please check if it is **UNACCEPTABLE** for us to contact you at ☐ Work ☐ Home

Client Social Security No.: _____ Client Birth Date: _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Client Working Status: ☐ Employed ☐ Full-time Student

Employer Name: _____

Emergency Contact (If problem arises with a schedules appointment)

Name: _____ Phone Number: _____ Relationship: _____

Who referred you? _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Policy Holder Name: _____

Policy Holder Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Policy Holder Social Security No.: _____

Policy Holder Birth Date: _____ ☐ Male ☐ Female

Policy Number: _____ Group Number: _____

Policy Holder Employer: _____

Policy Holder Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Client Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Mental Health Co-pay: _____ Deductible Amount: _____

Is there Secondary Insurance: _____ Name of Secondary Insurance Company: _____

If you have secondary insurance, please furnish us a copy of card.

PLEASE NOTE: It is your responsibility to familiarize yourself with your insurance coverage in regards to co-pay, authorizations and deductible. You are responsible to pay your co-pay and/or deductible at the time of session. By sighing this form, you are authorizing us to bill your insurance.

Client Signature: _____

Parent Signature (if applicable): _____

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Therapist: _____ Client Diagnosis: _____ Computer ☐