Client Information

Welcome! In order to better serve you, we request that you provide the following information:

Name: _____
First M Last

Address: _____
Number Street City State Zip code

Email:_____

Phone Numbers: _(___)_____ (___)_____(___)_____
Home Work Cell

Preferred method of communication, including leaving a message (please circle): home phone, work phone, cell phone, email

Social Security Number: _____ **Birth date**: _____**Age**_____ **Marital Status**: _____

Employer: _____ **Occupation**: _____

I agree to pay my copay of _____ at the end of every session. **If I am self paying**, I will pay _____at the end of each session.

How did you hear about our practice? _____

May we include you in our electronic newsletter list? YES __ NO __ (All addresses are kept private)

Insurance Information

Insurance Co. Name: _____ **Address: _**_____

Member ID# _____Group #/Name: _____

Policyholder's Name (if different than above): _____
First M Last

Address & phone number (if different than above): _____

_____

Insured's Employer Name: _____ **Insured's Birthdate**: _____

Insured's Relationship to Client: _____ **Plan year starts**: _____

Insurance Co Phone # to verify coverage: _____ **Are authorizations required for treatment?** YES ___ NO ___

Annual deductible for behavioral health: _____

Limits of coverage: _____ **Do you have a secondary insurance policy**: YES __ NO __

For office use only:

DX:
INS: