Client Information Form

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Client Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Employer: _____ Last 4 digits of Social Security #: _____ Marital Status: _____

Birth Date: _____ Age: ____ Gender: _____ Email address: _____

Responsible Party Information

Responsible Party is Patient: Yes No (If yes, please leave section blank)

First Name: _____ Last Name: _____ Relationship to Patient: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Financial and Policy Holder Information

Primary Insurance:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Birth Date: _____ Relationship to Patient: _____ Gender: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Insurance Telephone #: _____

Secondary Insurance: Yes No

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Birth Date: _____ Relationship to Patient: _____ Gender: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Insurance Telephone #: _____

* See attached "Counseling Consent" for more information about third-party payers.

I acknowledge that I have read this form and understand its purpose and content. I agree to provide any updates to this information in a timely manner to the therapist.

_____ _____

Client (or authorized Representative/Relationship to Client) Date