Client Information Form

Client Name_____ New Client? □ Client Update? □
Must be full, legal name of the person being seen for therapy

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender □ M □ F

Home Phone _____ □ Y □ N
May I leave a message?

Work Phone _____ □ Y □ N
May I leave a message?

Other Phone_____ □ Y □ N
Please identify May I leave a message?

Client Marital Status
□ Single □ Married □ Other

Client Employed?
□ Yes □ No

Client Student Status
□ Full Time □ Part Time

Email:_____ May we text your cell phone? □ Y □ N

How Did You Hear About My Practice? ***Please be as specific as possible***

Name _____ □ Former/Current Client □ Website □ Print Media

□ Healthcare Professional □ Mental Health Provider □ Insurance Company □ Word of Mouth

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please complete any information that differs from the client.***

Name_____ Home Phone_____

Address_____ Work Phone_____
Street or PO Box

_____ Relationship to Client:_____
City State Zip

Insurance Information ***Information in this section should pertain to the Primary Person listed on the insurance card. Please complete any information that differs from the client.***

Insurance Co_____ Insurance Phone#_____

Insured's Name_____ ID#_____

Group#_____ Patient Relationship to Insured □ Self □ Spouse □ Child □ Other

Insured's Address _____ Home Phone_____
Street or PO Box

_____Insured's SSN_____
City State Zip

Insured's DOB_____ Gender □ M □ F Insured's Employer_____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature_____ Date_____

Office Use Only Provider _____ Diagnosis Code_____

Billing Notes_____

Form Updated 02/14/14