

CLIENT INFORMATION FORM

Please fill in the information below and bring to your first session or email to dg@diannegerard.info. Please note information you provide here is protected as confidential information.

TODAY'S DATE: _____

NAME: _____

BIRTH DATE: ____/____/____ AGE: _____

ADDRESS: _____

(Street and Number)

(City)

(State)

(Zip Code)

HOME PHONE: _____ MAY I LEAVE A MESSAGE? Y ____ N ____

CELL PHONE: _____ ****WITH YOUR CONSENT, DL GERARD PC WOULD LIKE TO SEND TEXT MESSAGES TO THE NUMBER YOU HAVE PROVIDED ON THIS FORM. PLEASE PLACE A CHECK MARK NEXT TO YES ____ OR NO ____ TO RECEIVE TEXT (SMS) MESSAGES. THESE SMS MESSAGES ARE FOR INFORMATIONAL PURPOSES ONLY. (SMS) TEXT MESSAGING CONSENT OR PHONE NUMBERS FOR SMS ARE NOT SHARED WITH ANY THIRD PARTY OR AFFILIATIONS FOR ANY PURPOSE. (Please refer to my privacy policy on the INFO page under HELPFUL FORMS).**

EMAIL ADDRESS: _____

OK TO SEND CORRESPONDENCE OR STATEMENTS? YES ____ NO ____ (*Please note, email correspondence is not considered to be a confidential means of communication).

REFERRED BY (IF ANY): _____

REASON FOR SEEKING TREATMENT: _____
_____.

FINANCIALLY RESPONSIBLE PARTY:

CLIENT _____ INSURED PERSON (OTHER THAN CLIENT) _____

INSURED PERSON'S (OTHER THAN CLIENT) INFORMATION:

INSURED PERSON'S NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

HOME # _____ WORK # _____

CELL # _____ (no correspondence or texts will be sent)

INSURED DATE OF BIRTH _____ / _____ / _____

INSURANCE COMPANY: _____

INSURED ID# _____

GROUP PLAN # _____

INSURANCE CO PHONE # _____

EMPLOYER OF POLICYHOLDER _____

INSURANCE EFFECTIVE DATE: _____

**** I do not bill secondary insurance; however, I will provide everything you need to do so.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW:

I give permission to Dianne Gerard (DL GERARD PC) and billing staff to send the required information to my insurance carrier. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as co-pays, deductibles, and non-covered services. I also understand there is a \$75 fee if I fail to give at least 24 hour's notice for cancellation of my appointment. I understand that my insurance carrier does not cover the cost of missed sessions.

Signature of Client

Date

Signature of Responsible Party (if different than client)
