CLIENT INFORMATION FORM

Please provide the following information and answer the questions below. **Please note**: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Date of appointment: _____

Client Name: _____
(Last) (First) Middle

Name of parent/guardian (if under 18 years):

_____
(Last) (First) Middle

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Client's SS# _____/_____/_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Address: _____
(Street and Number)

_____
(City) (State) Zip Code

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May I leave a message? □ Yes □ No

Work Number: ( ) May I leave a message? □ Yes □ No

Email address:_____Okay to send correspondence or statements?

Employer Name:_____ City_____

Referred by (if any): _____

Reason for seeking treatment:_____

Would you like me (Dianne Gerard) to communicate information to your Primary Care Physician, Family Physician, Psychiatrist, School Counselor or any other outside professional? □ YES □ NO
If yes, please fill out **Authorization to Disclose Information Form** under **Helpful Forms.**

FINANCIALLY RESPONSIBLE PARTY: □ Client □ Insured Person (other than client) □ Other

Client's relationship to policyholder: □ self □ spouse □ child □ other

INSURED PERSON'S INFORMATION:

Insured Person's Name: _____

Home Address: _____

City:_____ State ____ Zip Code:_____

Home # ( ) _____Work # ( )_____ Cell # ( ) _____

Insured Date of Birth: _____/_____/_____

INSURANCE COMPANY:_____ □ PPO □ HMO □ OTHER

Insured ID#_____ Insured SS# _____/_____/_____

Group Plan#_____ Insurance Co. Phone #_____

Employer of Policyholder _____ Insurance Effective Date: _____

Insurance Claims Mailing Address:_____

_____

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, LCPC, and billing staff to send required information to my insurance carrier or my EAP. 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 notice for cancellation of my appointment. I understand that my insurance carrier or my EAP does not cover the cost of missed sessions.

_____
Signature of Client (age 12 and older)

_____
Signature of Responsible Party (if different than client)

_____
Date