# CLIENT INFORMATION

NAME: ____________________________________ AGE: ________ DATE: ___________

ADDRESS: ____________________________________________________________________
Street or PO Box Town State Zip

DATE OF BIRTH: _____________________________ TELEPHONE (H) ______________

MARITAL STATUS: ________________________ TELEPHONE (C or O) ______________

E-MAIL ADDRESS (OPTIONAL) ________________________________________________

MAIDEN NAME _____________________ SOCIAL SECURITY # _____________________

EMPLOYER ______________________________ REFERRED BY _____________________

INSURANCE #1 _____________________________ CERTIFICATE # ___________________

GROUP # ______________________________ SUBSCRIBER ________________________

INSURANCE #2 _____________________________ CERTIFICATE # ___________________

GROUP # ______________________________ SUBSCRIBER ________________________

PERSON RESPONSIBLE FOR PAYMENT ___________________________________________

ADDRESS (If different from above) _______________________________________________
Street Town State Zip

******************************************************************************

**INSURANCE RELEASE, FEE AGREEMENT, AND CONSENT**

I consent to allow treatment for the first person(s) listed above. I authorize the release of any medical information necessary to process insurance claims. I acknowledge full responsibility for the payment for psychological services and agree to pay in full for the portion(s) not covered by insurance at the time of services unless other arrangements are made with the psychologist. I understand that is fees are not paid within a reasonable time, interest will accrue and legal action may be taken to recover money owed.
**I understand that I will be required to pay a "No Show" fee for appointments missed without 24 hour notice to the psychologist.**

_____________________________________ _____________________________
Signature of person responsible for payment Date