

ROSEMARY PRIEST, LPC, LMFT, LMHC, NCC

2021

Client Information Form

Date: _____ Time: _____ Referred by: _____ Acct # _____

PERSONAL INFORMATION:

Last Name: _____ First Name _____

Middle Initial _____ Maiden Name: _____ Nickname: _____

Date of Birth (e.g, 3/3/1956) _____ Age: _____ SSN _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone _____ Ext _____

Cell Phone _____ Email address: _____

Gender: _____ Male _____ Female _____ Other _____

Marital Status: _____ Single _____ Married _____ Other _____

Employment Status: _____ Employed; _____ Full-time student; _____ Part-time student _____ Other _____

Employed by: _____

Emergency contact: (name and number) _____

Other Responsible Party: (who pays bill?) _____

Responsible Party Street Address: _____

City _____ State _____ Zip _____ Phone _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ ID # _____

Group # _____ Effective Date: _____

Insured Name (Last,First, MI) _____

Insured's Address: _____

Insured's Phone _____ Insured's DOB _____

Insured's Gender: _____ Male _____ Female _____ Other. Rel. to you: _____

Insured's Employer _____

Insurance Benefits:

Annual Deductible: _____ Met? _____ yes _____ no

Co-Pay or Usual Fee: _____ Precert req'd _____ yes _____ no

Using an Employee Assistance Program? Name of EAP _____

Auth # _____ # of EAP sessions authorized _____

EAP Cert.start date _____ EAP Cert End Date: _____

Secondary Insurance (if any) _____

Other Insured Name (Last, First, MI) _____

Relationship to Client: _____ Policy # _____ Group # _____

Appointment Reminder Preferences: _____ None requested

_____ Email (address required) _____

_____ Text (cell #) _____ Carrier name: _____

_____ Phone call (requires home phone #) _____

CLIENT SIGNATURE: _____