Letitia D. Brown, LCSW
Caring for Our Community

Client Information

Client Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell/Home Phone: _____ Alternate Phone: _____

Marital Status: _____ DOB: _____ SS# _____

Gender: _____ Race/Ethnicity: _____

Referral Source: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Parent/Guardian (if applicable): _____

Patient/Guardian Employer: _____

Client's Primary Insurance: _____ Policy #: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Reason for Seeking Services: _____

Appointment Reminders

Please check the box with your preferred method to be noticed of your appointment date & time
(Only select one option)
Reminders may be given up to 3 days in advance depending on the date of your appointment

☐ **Email Reminder:** _____

☐ **Phone Call: (____) _____ - _____ Are Voicemails with Appt. Time & Date OK?: □ Yes □ No**

☐ **No Reminder**

Email and text are not secure forms of communication. Please do not email or text clinical information. I agree that appointment reminders are strictly a courtesy and understand missed appointments are my financial responsibility that will not be covered by my insurance. My signature below shows that I understand and agree with these terms.

_____ _____ _____

Client/Guardian Signature/Print Relationship to Client Date