Judi Daly, MSW, LICSW
525 Hercules Dr. 1A, Colchester VT 05446 802-264-5333 ext 106

New Client Data Form

If you are answering for a child, please provide the answers based on the child's life.

Name of Client: _____ Date of Birth of Client:_____

Name of parents or guardians (if client is a minor):

Parent one:_____Parent two: _____

Gender: _____ Marital/Relationship status: _____ Number of children:_____

Phone numbers- Home_____Cell_____Work_____

Which number may I call you at and leave a message at if I need to reach you?_____
Email Address:: _____(note that I do not use email for confidential correspondence)

Complete home (and mailing address if different):

_____

_____

Emergency Contact Name _____
Relationship:_____ Phone number_____

Physician Name_____Phone_____Address_____

Referred by/Relationship:_____

Occupation/ Employer, or for child, Name of School/Grade

_____

_____

Who lives in your household/relationship to client?

_____

_____

INSURANCE INFORMATION: (Please Bring your card(s) with you to first appointment

Primary Insurance: Name of insurance Co: _____

Subscriber name: _____

Relationship to Client : (circle) *self spouse parent other*

Insured ID#_____

Group #: _____Deductible /CoPay amount _____ Date Authorization Starts/ends _____

Prior Authorization Required *Y N* **Have you requested it yet** *Y N* **Pre- Authorization #_____**

If Applicable:

Secondary insurance Co: **_____Subscriber name:_____**

Relationship to Client : (circle) *self spouse parent other* **Insured ID#_____**

Group #: _____Deductible /CoPay amount _____

Prior Authorization Required *Y N* **Have you requested it yet** *Y N* **Pre- Authorization #_____**

Date Authorization Starts/ends _____

Person responsible for the bill: _____

Address if different from yours: _____

By signing below you consent to psychotherapy with Judi Daly, LICSW and you authorize me to disclose to your insurance company or other authorized benefits provider, or party that pays for any part of or all of your care, all information that is customary and necessary to process your benefits/ claims. You also authorize Judi Daly LICSW to submit billing on behalf of the above named client to receive payment for services and authorize payments to be made directly to me, Judi Daly LICSW, as appropriate. It is understood that this does not guarantee the payment of such a claim; that such payment is solely the responsibility of the client (or parent/guardian) and or the benefit provider. By signing below you acknowledge that full payment is expected, and that Judi Daly LICSW may submit to a third party collections agency any past due balances that are over 60 days after the termination of services, for the purpose of obtaining payment for said balances and that legal action could be taken to retrieve delinquent payments.

My signature below indicates that I have read this form and understand its contents:

Signature *(of client or parent/guardian)*_____ Date: _____

Signature *(of client or parent/guardian)*_____ Date: _____