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CLIENT INFORMATION SHEET

Name_____Birth date_____Age_____
Address_____ City _____State_____ZIP_____
SS#: _____ EMAIL: _____
Phone: Home_____ Work_____ Cell_____
May we call and leave messages at these numbers? Yes No If not, how may we reach you?
_____
Employer _____ Occupation _____
How long ? _____ Education _____
Are you under a physician's care? _____ Physician _____
Phone number _____
Identify medical conditions _____
List Medications and dosages: _____
Relationship Status: __ Single __ Cohabiting __ Married __ Partnered __ Separated __ Divorced __ Widowed
List Children (ages) _____
Do you have custody? _____ If not who does?_____
Name of Emergency Contact: _____ Relationship: _____
Phone: Home_____ Work_____ Cell_____
Referred By :_____
Do I have your permission to thank them for the referral? Y N

Employee Assistance Program clients must comply with the stipulations of their company policy, which was explained when you called the toll free number. Fees for EAP sessions are covered by your policy. No– shows and late cancellations may be charged to you directly. PLEASE NOTE: Appointments must be cancelled 24 hours prior to the appointment; otherwise, you will be charged the full fee. It is customary for payment for professional services to be made following each session. An 18% interest rate will be applied to accounts over 60 days old. Each client is provided with an information sheet that covers essential information. If this office does bill your insurance company, your signature authorizes the release of any medical or other information necessary to process the claims and you authorize third party payment for services rendered. Please understand that you are financially responsible for services rendered, including collections fees.

Please sign below to indicate that you have received and read these notations.

SIGNATURE:_____ DATE _____

If you have any questions, I would be happy to discuss them with you. – Lisa A. Smith