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Client Information Sheet

Todays Date:

Client Name

Date of Birth:

Address:

City:

Zip:

Relationship Status:

E-mail:

Preferred Phone (Cell, Home):

Work Phone:

Employer/School name:

Job Title:

Spouse/Partner's Work

Spouse/Partner & Family Names	Relationship	Age	Occupation	School

Who referred you to this office?

Reasons for referral?

Name of person who can be contacted in case of emergency:

Address: Phone:

Name of Physician:

Date of last physical:

May I notify your physician that you have contacted me?: __ Yes __No

Present medical or physical problems?:

Present medications?:

Name(s) of previous psychotherapist(s), counselor(s) or psychiatrist(s):

Name: Dates seen:

Name: Dates seen:

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I have read the Office Policy and Informed Consent Statement and kept it for my records. I agree to abide by all arrangements described therein. The information has been reviewed with me, and I understand it fully.

Signature _____ Date _____

I assume responsibility for canceling appointments at least 24 hours in advance or I will pay for the missed appointments in full.

Signature _____ Date _____

Insurance Verification

Client name:

Address:

Preferred Phone (home, cell or work):

Email:

Date of birth:

PRIMARY INSURANCE

DSM IV:

Client relation to insured:

Insured's name:

Insured's address:

Employer:

Primary Insurance Company:

Insurance Address:

Insurance Phone #:

Identification #:

Insurance Group #:

Deductible Amount:

Met? __Yes __No

Preauthorization required?: __No

If yes, through:

Limits of mental health coverage?:

sessions/year?:

$ amount/year?:

Mental health benefit available: all

or part $:

SECONDARY INSURANCE

Client relation to insured:

Insured's name:

Insured's address:

Employer:

Social Security #:

Driver's License #:

Secondary Insurance Company:

Insurance Address:

Insurance Phone #:

Insurance Group #:

Identification #:

Deductible Amount:

Met? __Yes__No

Preauthorization required?: _ No

If yes, through:

Limits of mental health coverage?:

sessions/year?:

$ amount/year?:

Mental health benefit available: all

or part $:

Dr. Janet B. Reigel, Psy.D. has my permission to bill my insurance(s), (HMO, PPO, EAP). I authorize her to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to Dr. Reigel.

Signature _____ Date _____