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New Client Information

Today's Date: _____

Name: _____ Birth date: ___/___/___ SS #: _____

Address: _____ City & State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email address: _____

Emergency contact: name: _____ phone: _____

Relationship: _____

Insurance Information: Before coming to your first visit, please look on the back of your card for information on "mental health" or "outpatient psychotherapy" benefits. Please call your insurance company and complete the information with their help:

Policy Holder's Name: _____ Birth date: ___/___/___ SS #: _____

Policy Holder's Address (if different): _____

Insured's Employer: _____

Relationship to patient: _____

Mental Health Insurance Carrier (Primary) _____

Policy or ID #: _____ Group #: _____ Effective Date: _____

Authorization #: _____ Date auth. Starts / ends: _____

Number of Sessions Authorized: _____ Co-pay per session: _____

Address where mental health claims should be sent: _____

_____

Mental Health Insurance phone number to verify benefits: _____