

Client Information Please Print

Today's Date: _____

Seeing: Norma Vaillette

Client Information

Last Name	First Name	MI	Home Phone	Cell Phone	Other Phone
Mailing Address Street			DOB mm/dd/year	Age	Work phone
City, State, Zip			Gender: F M	Marital Status: M, S, W, Div, Sep	
Primary Reason for making appointment			Secondary Problem or Issue		
Highest Grade Level (name of school)			Work		
Medications			Email Address		
Referred by					

Responsible Party

Relationship to client: _____

Last Name	First Name	MI	Home Phone	Cell Phone	Cell provider
Mailing Address Street			DOB mm/dd/year	Work phone	
City, State Zip			Gender: F M	SS#	
Email Address			Occupation		
Employer			Ok to contact you at work: Y/N		

Insurance Information

Insurance Company	Telephone
Mailing Address	Subscriber Name /Relation to Client
Identification #	Group # /Effective date
Subscriber mailing address (if different than Responsible Party)	Subscriber DOB. SS#

Emergency Contact Information

Name (someone not living with you)	relationship	Phone number	Alternate contact number
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I give consent for my counselor to contact my insurance company and release information to my insurance carrier and its agents for the purpose of providing care and securing payment. I understand that I am responsible for payment of services and charges not covered by my insurance company. I understand that payment is expected at the time of service. **I understand I need to give 24 hour notice for cancellation.**

Client Signature

Date

Responsible Party signature

Date