Date of Intake _____ Doctor _____

# Client Information Form – Child/Minor

**Client**

Legal Name: _____ Preferred Name: _____

SSN: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone No. (Home)_____ (Cell) _____

Custody held by: _____

School _____ Grade _____

**Referral**

Whom may we thank for referring you? _____

**Mother**

Name: _____ Phone No.: _____

Address:_____

Employer: _____

Phone No. (Home)_____ (Work) _____ (Cell)_____

At which of these numbers can you most easily be reached? _____

At which number can we leave a brief message if necessary? _____

**Father**

Name: _____ Phone No.: _____

Address:_____

Employer: _____

Phone No. (Home)_____ (Work) _____ (Cell)_____

At which of these numbers can you most easily be reached? _____

At which number can we leave a brief message if necessary? _____

**Billable Party**

Name: _____Relationship to Patient: _____

Address:_____

Phone No. (Home)_____ (Work) _____ (Cell)_____

Client _____

**Insurance**

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SSN: _____ Birth Date: _____

**Policy holder's SSN & DOB are required for filing insurance.

Please provide a copy of your insurance card.

**Signature**

Your signature below indicates that you have received, read, and agree to the terms of the following notices:

1. Alabama Notice Form (HIPAA)
2. Psychologist / Client Services Agreement
3. Fee Schedule (Last page of the Psychologist/Client Services Agreement)

_____

Signature of Client (age 14 or older) or Legal Representative Date