Doctor _____ **Date of Intake**_____

Client Information Form – Adult

Client

Legal Name: _____ Preferred Name**:** _____

SSN: _____ Birth Date: _____

Mailing Address: _____

City:_____ State: _____ Zip Code: _____

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? _____

Referral

Whom may we thank for referring you? _____

Billable Party

Name: _____Relationship to Patient: _____

Address: _____

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

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 of the

Your signature below indicates that you have received, read, and agree to the terms

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