CLIENT INFORMATION FORM

Paul David, Ph.D., LMFT, LMHC

Client Identification—*Please complete this section for those who will be receiving mental health services*:

Names & Ages _____

Contact Address _____ City _____Zip _____

Contact Phone _____ □CellPh □HmPh □Wk

Contact E-mail _____ Preferred Communication: □Ph □Email

Emergency Contact _____ Relationship _____ Phone _____

Financial Responsibility—*If you will be using health insurance, please complete this section:*

Name of Insured _____ Date of Birth ___/___ /____ Gender ____
(Policy Holder) (First, Middle, Last)

Covered Partner _____ Date of Birth ___/___ /____ Gender ____
(If Applicable) (First, Middle, Last)

Insured Address _____ City _____ Zip _____

Insured Employer _____ Type of Work _____

Insured Social Security No. _____ Driver License's No. _____

Insurance Carrier _____ Carrier's Phone _____

Policy ID _____ Group No. _____ Co-Pay Amount _____
(include all lettered prefixes)

Insurance Effective Date_____ Deductible Amount _____

Have you met your deductible ? Y / N
If you have not yet met your deductible, payment in full is due at the time of service.

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier. I further authorize payment of insurance benefits for services rendered to Paul David, Ph.D., LMFT, LMHC.

Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services. I also understand that I will be responsible for any late cancellation and no-show fees at a rate of up to $150.00 per session.

Client Signature _____ Date _____

Client Signature _____ Date _____