Patrick Baldwin, LCSW

CONFIDENTIAL CLIENT INFORMATION

Name_____ **Name I like to be called** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth ____/____/_____ **Male**____ **Female**____ **Marital status:** **Single** _____ **Married** _____

Email Address _____

Employer & Occupation _____ **Address** _____

Spouse/Significant Other (If applicable) and their Occupation _____

Child(ren) Name(s) and Age(s) (If applicable) _____

Name of Parent / Guardian (If client is a minor) _____

Best Way to Contact _____

GUARANTOR INFORMATION / INSURANCE SPONSOR

Name of Primary Insured _____ **Date of Birth** _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Address** _____ **Phone** _____

Insurance Co. _____ **Phone** _____ **Group #** _____

Member ID # _____

Secondary Insurance _____ **ID #** _____ **Group #** _____

EMERGENCY CONTACT

Name _____ **Relationship** _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

REFERRAL SOURCE

Whom may we thank for referring you to us? _____ **Address** _____ **Phone** _____

Reason for seeking counseling _____

I understand and agree that I am ultimately responsible for any deductible, co-payment amount, or any other balance not paid for by my insurance. I understand that I am responsible for paying for my therapy at the time of service. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, and I assign benefits payable, to which I am entitled, to the undersigned provider of service.

Client/Guardian Signature _____ **Date** _____

Provider's Signature _____ **Date** _____