Date of Intake _____ Doctor _____

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? _____

E-mail address_____

Physician

_____

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 Birth Date:_____

Please provide a copy of your insurance card.

Signature

Your signature below indicates that you have been provided with the following:

1. Alabama Notice Form (HIPAA)
2. Client Services Agreement
3. Fee Schedule

_____

Signature of Client Date

_____

Signature of Billable Party Date