Client Information

Today's Date:____________________

Last Name	First Name	MI	Birthday	Age

Street Address	City	State	Zip

Mark Best # To Call	Type	Phone #	Msg OK?	Email Address	
	Cell		☐		
	Home		☐	Y | N	Do you want to receive occassional emails about the practice, groups, seminars, workshops, & satisfaction surveys. (I will NEVER release email address to 3rd parties)
	Work		☐		

If client is a child, please list any parent or guardian that has at least legal custody of this child.

Name:	Name:
Relationship:	Relationship:
Occupation:	Occupation:
Address:	Address:

Mark Best # To Call	Type	Phone #	Msg OK?	Mark Best # To Call	Type	Phone #	Msg OK?
	Cell		☐		Cell		☐
	Home		☐		Home		☐
	Work		☐		Work		☐

Emergency Contact Info

	Mark Best # To Call	Type	Phone #	Msg OK?
Name:				
Relationship:		Cell		☐
Address:		Home		☐
		Work		☐

Who referred you or how did you learn about this practice?

Client Information (continued)

CLIENT'S PRIMARY DOCTOR / MEDICAL INFORMATION / PRIMARY DOCTOR RELEASE		
Practice and/or Doctor & Phone Number:	When was the you/your child's most recent physical exam?	
	Please list any allergies that pose a risk for you or your child:	

Because mental health is part of the health care system and one of the roles of your primary care physician is to assist in coordinating your overall care, it is often helpful to inform your primary care physician that you/your child have started therapy with me. Would you like to consent to me sending them a courtesy letter that contains a brief mention of the "symptoms" (to use the medical term) that brought you here today? (This is completely optional.)

Pleaes initial one option below…

__________ **Yes,** I would like you to notify my/my child's primary care physician, as detailed above. __________ **No**

FINANCIAL INFORMATION / RELEASE

(1) **If client is a minor** and parents aren't married, who is legally responsible for paying this medical expense?

Please provide name and relationship below…

Name: Relationship:

(2) **If client is an adult**, is there another family member or person in your life that you want to give me permission to speak to regarding payment and billing issues?

Pleaes initial one option below…

__________ **Yes,** I would like you to contact: __________ **No**

If the answer to either question (1) or question (2) above whose contact information is not already listed on the first page of this form, please provide this information below.

Name:	Mark Best # To Call	Type	Phone #	Msg OK?
Relationship:		Cell		☐
Address:		Home		☐
		Work		☐

I attest that the information I have reported in this form is accurate to the best of my knowledge. Further, my signature below finalizes my above initialled preferences regarding the release of information to my primary care physician and regarding my financial obligations to this practice.

Print Name Signature Date

ANDREA MORGANSTEIN, LPC, LLC
203 W. Chestnut Street, Ste 202
West Chester, PA 19380
610-314-0799