

Today's Date: \_\_\_\_\_

# Client Information

Last Name		First Name		MI	Birthday		Age
Street Address				City		State	Zip
Mark Best # To Call	Type	Phone #	Msg OK?	Email Address			
	Cell		<input type="checkbox"/>				
	Home		<input type="checkbox"/>	Y   N	Do you want to receive occasional emails about the practice, groups, seminars, workshops, & satisfaction surveys. (I will <u>NEVER</u> release email address to 3rd parties)		
	Work		<input type="checkbox"/>				
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		<input type="checkbox"/>		Cell		<input type="checkbox"/>
	Home		<input type="checkbox"/>		Home		<input type="checkbox"/>
	Work		<input type="checkbox"/>		Work		<input type="checkbox"/>
Emergency Contact Info							
Name:				Mark Best # To Call	Type	Phone #	Msg OK?
Relationship:					Cell		<input type="checkbox"/>
Address:					Home		<input type="checkbox"/>
					Work		<input type="checkbox"/>

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		<input type="checkbox"/>
Address:		Home		<input type="checkbox"/>
		Work		<input type="checkbox"/>

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**  
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