CONFIDENTIAL CLIENT INFORMATION (page 1 of 2)

Welcome to my practice. Please fill out the following questions as completely as possible.
PLEASE PRINT OR WRITE LEGIBLY.

Client's Name	Ms. / Mrs. / Mr. Last First Middle	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Client's Address	Street:	
	City: State: Zip code:	
Phone	Home: ( ) Work: ( )	
	Age: Birthdate: Birthplace:	
Education	No. of years: Degree: Field:	
	Religious background: Current religion:	
Spouse	Name: Age: Occupation: Years Married:	
Children	M F Name: Age: M F Name: Age: M F Name: Age:	

Were you raised by: Both parents? Single parent? Relative? Other?

Father's name: Age: Occupation:

Mother's Name: Age: Occupation:

Brothers and sisters (including yourself) in birth order: Name: Age: Name: Age:

Name: Age: Name: Age: Name: Age:

In your family was there a history of: ☐ Alcoholism? ☐ Substance abuse? ☐ Mental illness?

☐ Prolonged physical illness? What kind?

Current medications:

Significant medical problems:

Have you had previous psychiatric care and/or counseling? ☐ Yes ☐ No

If yes, give: Name of clinician Degree/License Sessions from to

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders?

☐ Yes ☐ No Details:

CONFIDENTIAL CLIENT INFORMATION (page 2 of 2)

Client or Guardian employed by:			
Employer's address:			
City:	State:	Zip:	Phone ( )
Name of insurance company:		Name of insured:	
Group No.		Member No.	
Driver's License No.		Social Security No.	
Insurance company billing address:			
City:	State:	Zip:	Phone ( )
Spouse employed by:			
Employer's address:			
City:	State:	Zip:	Phone ( )
Name of insurance company:		Name of insured:	
Group No.		Member No.	
Driver's License No.		Social Security No.	
Insurance company billing address:			
City:	State:	Zip:	Phone ( )

The undersigned herby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for service rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, (Name of Insured)_____hereby authorize (Insurance Company)_____to pay and hereby assign directly to Ann M. Frank, Psy.D., all benefits if any otherwise payable to me for her services as described on the attached forms. I understand I am financially responsible for all charges incurred and I expect that any insurance benefits, when received by and paid to Ann M. Frank,Psy.D. will be credited to my account, in accordance with the said assignment.

_____

(PATIENT OR AUTHORIZED SIGNATURE) (DATE)

Client's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

I will be happy to discuss my fees, schedule of payments, or any other questions relating to billing or insurance. Please do not hesitate to ask.