Counseling & Psychology Resources

A CENTER FOR COUNSELING AND PSYCHOLOGICAL HEALTH CARE
Gary S. Indenbaum, Ph.D., LP

CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully or ask for assistance if you do not understand an item.

Full name: _____ Today's Date: _____
Address: _____
City: _____ Zip: _____
Phone: Primary: _____ Secondary: _____
Date of Birth: _____ Age: _____ Marital Status: _____
Employer: _____ SSN: _____
Occupation: _____ Education: _____

Briefly describe your reason for seeking assistance:

Who suggested you contact our office?

Who is your primary health care provider (physician)?

List any major health problems for which you are being treated:

List any medications you are now taking:

Have you ever received psychiatric, psychological, or counseling services?
If yes, explain:

List members of your family or others in your home:

Name	Age	Relationship	Occupation

In the event of an emergency, please call: _____
Relationship: Phone:

Agreement for Counseling or Psychological Services

I, _____, the client, agree to keep all scheduled appointments and understand that 24-hour notice is required for cancellation. I agree to pay for appointments that are not cancelled within 24 hours unless a legitimate emergency occurs. I understand and accept that I am fully responsible for all charges and that all fees or co-pays are due at the time the service is provided unless other arrangements have been made. *Please remember, in most cases, your insurance carrier has an agreement with you, not our office, to assist with payment of your health care costs. We strongly encourage you to contact your carrier directly concerning your outpatient mental health or other health care benefits.*

I understand that necessary information will be provided to my insurance carrier, in order to process any claim made for services.

My signature below means that I understand and agree with all points above.

_____
Signature of Client Date

Referral Release Form

Our office would like to extend our appreciation and communicate with your physician or other professional that referred you to our office. Your signature below authorizes us to do so.

Name of Referring Professional (e.g. Physician or Attorney): _____
Address: _____

Signature of Client: _____ Date: _____