CLIENT INFORMATION SHEET

NAME:

ADDRESS:

CITY:

ZIP CODE:

HOME PHONE :

EMAIL:

BIRTHDATE :

Cell Phone: Work Phone:

Phone # you prefer to be called on:

Marital Status:

Primary Insurance:

Policy Holders Name:

Relationship to Client:

ID# Group#

Telephone # of Insurance

Referred by:

I authorize Susan C. Sullivan PMHCNS.,BC, Psychiatric/Mental Health NP,
to release any information about my treatment that is necessary to process insurance claims. I understand that I am responsible for all charges regardless of insurance coverage. I further understand that I am responsible for any sessions that are cancelled with less than 24 hours notice.

Signature: Date: