Client Information

LAST NAME_____FIRST NAME_____MI_____

PARENT NAME (IF UNDER 18)_____

ADDRESS_____CITY/STATE_____ZIP_____

HOME PHONE ( )_____ OK TO LEAVE A MESSAGE? YES/NO (CIRCLE)

WORK PHONE ( )_____OK TO LEAVE A MESSAGE? YES/NO (CIRCLE)

CELL PHONE ( )_____OK TO LEAVE A MESSAGE? YES/NO (CIRCLE)

EMAIL ADDRESS _____

AGE_____DATE OF BIRTH_____/_____/_____ MALE/FEMALE (CIRCLE)

SS#_____ MARITAL STATUS_____

IF YOU ARE UNAVAILABLE CAN WE LEAVE INFORMATION WITH SOMEONE OTHER YOU THAN ON

VOICEMAIL? YES/NO (CIRCLE) NAME OF PERSON IF YES_____

EMERGENCY CONTACT_____RELATIONSHIP_____

PHONE NUMBER_____

Client Authorization

I hereby authorize Anne G. Walker, LCSW to furnish information to insurance carriers concerning my illness and treatment. I hereby authorize benefits to be paid directly to her for mental health treatment services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance. I am aware that unpaid balances beyond 90 days will be considered past due and can be forwarded to a collection agency. I have received a copy of Ms. Walker's client contract and notice of privacy practices and agree to proceed with care. I will contact her if I have any questions.

I agree to not use any recording devices during a session without specific prior consent between myself and Ms. Walker. This is to ensure a safe and therapeutic environment for all clients.

Unless cancelled at least 24 hours in advance, I understand the policy is to charge for missed appointments at the full rate of a normal office visit. ***Clients will be billed directly for this fee, as unattended sessions cannot be billed to an insurance company.***

CLIENT SIGNATURE_____DATE_____

PARENT/GUARDIAN (IF UNDER 18)_____