ELENA C. SCHREIBER, LMFT
P.O. Box 58
Mansfield Center, CT 06250
Phone: 860-786-8108 / Fax: 888-502-4995

CLIENT INFORMATION SHEET

Client #1	Client #2
Client #1 Name:_____	Client #2 Name:_____
DOB: _____ SSN: _____	DOB: _____ SSN: _____
☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced	☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced
Home Address Street:_____	Home Address (☐ check if the same as Client #1) Street:_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Best # to be reach at (circle one): Home / Cell / Work	Best # to be reach at (circle one): Home / Cell / Work
E-mail:_____	E-mail:_____
May I e-mail you? Yes / No **Please note: e-mail correspondence is not considered to be a confidential form of communication.	May I e-mail you? Yes / No **Please note: e-mail correspondence is not considered to be a confidential form of communication.
Occupation:_____	Occupation:_____
Primary Care Provider:_____	Primary Care Provider:_____
Emergency Contact Info (Name/Relationship)	Emergency Contact Info (Name/Relationship)
_____ Phone: _____	_____ Phone: _____

How did you hear about me?

INSURANCE INFORMATION

PRIMARY Insurance:_____ Effective Date:_____
ID#:_____ Group #:_____ Policy Holder's DOB: _____
Policy Holder's Name:_____ Relationship to client: ☐self ☐spouse ☐parent ☐other
Policy Holder's Employer:_____ ☐Full time ☐Part time

SECONDARY Insurance:_____ Effective Date:_____
ID#:_____ Group #:_____ Policy Holder's DOB: _____
Policy Holder's Name:_____ Relationship to client: ☐self ☐spouse ☐parent ☐other
Policy Holder's Employer:_____ ☐Full time ☐Part time

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of surgical/medical benefits to the provider, for services rendered by the provider in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider to release any medical information necessary to process my claims and determine benefits payable.

MEDICARE/MEDICAID: I hereby authorize payment of Medicare/Medicaid benefits be made to the provider on my behalf for services rendered. I authorize the release of any medical information needed to determine benefits or the benefits payable for related services.

Client #1 Signature: _____ Date: _____

Client #2 Signature: _____ Date: _____