INSIGHT PSYCHOLOGICAL SERVICES, LLC
CLIENT INFORMATION FORM

Name of Client: _____
(First) (Last)

Date of Birth:_____ **Sex:** M / F **Relationship Status:** M / S / W / D / P

Occupation:_____ **Physical Address:**_____

Mailing Address: _____
Permission to mail to the above address? Yes_____ No_____

Home Phone #: _____ **Work Phone #:** _____
Permission to call? Yes_____ No_____ Permission to call? Yes _____ No_____
Permission to leave a message? Yes_____ No_____

Cell Phone #: _____ ****Please circle the best number to contact you**
Permission to call? Yes _____No_____
Permission to leave a message? Yes_____ No_____

Email: _____
Permission to email? Yes _____ No_____
Would you like to be added to our emailing list? Yes _____ No_____

Current Medications: _____

Allergies: _____

Insurance Information:
Name of Insurance Company: _____
Member ID: _____ Group #: _____
Primary Insured Name: _____ D.O.B. _____

Emergency Contact Information:
Name: _____
Phone #: _____ Relationship to patient: _____

Assignment and Release
I certify that I, and/or my dependent(s) have insurance coverage with _____and assign directly to Insight Psychological Services, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize that use of my signature on all insurance submissions.

_____ _____ _____
Signature of Client, Parent, or Guardian* Printed Name of Client Date Signed