CLIENT INFORMATION FORM

Patient Name:____ Appointment Date ____/_____/_______
Last First Middle

Preferred Name:_______________________Birth Date:___/___/_____ Age:_____Gender (Per Insurance): ☐M ☐F

Preferred Pronoun: ☐He ☐ She ☐ They ☐ None Current Gender Identity: ☐ M ☐ F ☐ Non-Binary

Address:____ Apt.# _________________

City: ____ State: ________ Zip Code: __________________

All statements and office correspondences will be sent to the above address unless otherwise indicated below.

Please check the numbers /methods of contact that you consent to leave a message:

☐Home Phone(____)____-______ ☐Cell Phone(____)____-______ ☐Email_______________________________

Other Numbers ☐ _______________(Name) (____)____-______ ☐ _______________(Name) (____)____-______

Patient's SS#:_____________________ Race:_________________________ Marital Status:_________________

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Homemaker ☐Disabled **Student:** ☐FT ☐PT ☐Not Student

Emergency Contact Person: ____________________ Phone Number: (____)____-______ Relationship_____________

IF MINOR: Mother's Name_____________________________ Father's Name______________________________

Name(s) of ***all Legal*** Guardian(s):_____________________________________ Phone Number: (____)____-______

Client lives with: ☐Both parents ☐ Mother ☐ Father ☐ Other _______________________________________

PLEASE COMPLETE ALL SECTIONS

Name of Provider you are seeing today?

____

Who referred you to the provider you are seeing today?

____

****PLEASE REVIEW**:** By signing this line, I agree to travel to this physician's location once Telehealth is no longer an option or should the physician require me to come to the office for treatment. You also MUST be in a CONFIDENTIAL area during Telehealth Session.

_________________________________ _______________
Signature: Date:

Do you want your clinician to communicate treatment information with your Primary Care Physician (PCP)?
PCP is your Internist, Pediatrician or Family Physician, not your Psychiatrist. ☐ **YES*** ☐ **NO**

***IF YOU CLICK "YES" YOU MUST COMPLETE THE EXCHANGE OF INFORMATION FORM.**

If you want information shared with other outside professionals, family or agencies please let your MD/Therapist know.
Please note, no information will be shared with any NON PRA professional, family or agency without your written consent.

Financially Responsible Party: ☐ Patient ☐ Insured Person (other than patient) ☐Other_______________

Patient's relationship to the policy holder: ☐self ☐spouse ☐child ☐other:____________________________

Insured Person's Information:

Insured Person/Responsible Party Name ____

☐ Address same as patient **(Where statements are mailed)**

Address:____ Apt.# ________________

City: ____ State: ________ Zip Code: __________________

Home # (____)____-______ Work # (____)____-______ Ext. _______ **Insured Date of Birth:**___/____/______

Insurance Company:____ ☐ HMO Site #_________ ☐ PPO ☐ POS

Insured ID#: ____ **Insured SS#:**______________________

Group/Plan #: ____________________________ **Insurance Co. Phone** #: (   )_______-______________

Employer of Policy holder: ________________________ Insurance Effective Date: _____/_____/________

☐ **Self Pay -** I understand visits will not be billed through insurance by PRA.

Do you have a secondary insurance? ☐ YES ☐ NO **If YES, please give a copy to this office.**

Secondary Insurance Company Name:______________________________________**Phone:** (____)____-______

Second Insurance ID#_________________________ **Second Insurance Group #**________________________

Revised 09/2021

White Copy: Therapist/MD file **Yellow Copy: Billing**