

CLIENT INFORMATION FORM

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

Preferred Name: _____ 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.

Please check the number(s) where we have your consent to contact you/leave a message:

Home Phone () _____ Work Phone () _____ Ext. ____ Cell Phone () _____

Which number would you prefer us to try first? Home Work Cell Second?: Home Work Cell

Patient's SS#: _____ Birthdate: ____/____/____ Age: _____ Marital Status: _____

Race: _____ 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? _____

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 want information shared with other outside professionals, family or agencies please let your MC/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: (circle one) 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.**

OUR OFFICE DOES NOT BILL SECONDARY OUT OF NETWORK INSURANCE COMPANIES. THIS IS THE RESPONSIBILITY OF THE CLIENT. WE WILL PROVIDE ALL INFORMATION FOR THE CLIENT TO BILL SECONDARY INSURANCE COMPANIES DIRECTLY.