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.

Revised 7/2019

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