Joyce Coleman, MS, LCSW
1810 Craig Rd. Ste 203
St. Louis, MO 63146
(314) 509-3310

CLIENT INFORMATION FORM

Today's Date: _____/_____/_____ Referred by: _____

Client's Name_____ DOB: _____/_____/_____
(Please print)

Home Address: _____

City: _____State: _____Zip_____

Email Address: _____

Marital Status: (circle one) Single Married Divorced Separated Widowed/Widower

Children/ages: _____

_____

Home Telephone: _____Cell: _____Work: _____

Medical conditions: _____

_____

Medications currently taking: _____

_____

Name of primary care physician: _____Phone # _____

Employer/Occupation: _____

Emergency Contact: _____ Relationship: _____Telephone: _____

Partner's Name: _____ DOB: _____/_____/_____

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INSURANCE INFORMATION

Primary Insurance Company: _____

Telephone No.: _____

ID #_____ Group # _____

Authorization # _____

Name of person who carries this insurance: _____

Secondary Insurance Company: _____

Telephone No.: _____

ID #_____ Group # _____

CANCELLATION POLICY

I have been informed that appointments cancelled less than 24 hours are subject to a $50.00 charge.

Client: _____ Date: _____/_____/_____
(SIGNATURE)

INFORMED CONSENT FOR TREATMENT

I consent to have this office perform psychotherapy and/or related mental health treatments when deemed necessary or advisable.

Client: _____ Date: _____/_____/_____
(SIGNATURE)

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I authorize this office to release only medical information necessary to process my claims for treatment in this office. I permit a copy of this authorization to be used in place of the original. I authorize this office to apply on my behalf for covered services rendered and request payment from my insurance company be made directly to them.

Client: _____ Date: _____/_____/_____
(SIGNATURE)