

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)