Client Demographic Information Today's Date____________

Client's Name: ________________________________ DOB: ______________

Parent's Name(s) (if applicable)____

Address: ____

Phone #s: Work: ______________ Cell: _____________Home:________________

Ok to leave message: **Y N** **Y N** **Y N**

Employer & Location: ____

If I Need to Contact Someone about You: If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you – perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write the name and information of your chosen contact person in the spaces below:
Name: ____

Address: ____

Phone numbers: ______________________________ Relationship to you: ____________

Insurance Information: if we accept your insurance and you want us to bill your insurance company for services here, complete the following:

Insurance Co.: ____

ID #: _______________________________________ Group #: _______________________________

Subscriber's Name (if not you): ____

Subscriber's Address (if not you): ____

Subscriber's DOB (if not you): _______________________Relationship to you: _______________

I request payment of authorized insurance benefits to be made on my behalf to: Gina Daniel, LCSW for services furnished to me by her. I authorize GLD or her employees to release to the Insurance Company and its agents any information needed to determine the benefits and reimbursement payable for services. I permit a copy of this authorization to be used in place of the original.

____ _________________________

Your Signature ***Date***