

SAMANTHA SLAUGHTER, PSYD

## CLIENT INFORMATION FORM

Today's Date: \_\_\_\_\_

Diagnosis Code(s): \_\_\_\_\_  
(please leave blank)**YOUR INFORMATION**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent's name (if client is under 18): \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Home: (\_\_\_\_\_) \_\_\_\_\_ May I call this number? Y N Leave a message? Y N

Work: (\_\_\_\_\_) \_\_\_\_\_ May I call this number? Y N Leave a message? Y N

Cell: (\_\_\_\_\_) \_\_\_\_\_ May I call this number? Y N Leave a message? Y N

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Name of Spouse/Partner (if applicable): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

It is okay to contact this person: \_\_\_\_\_

Client Signature

Date

School Attending (if applicable): \_\_\_\_\_

Name of person referring you: \_\_\_\_\_ May I thank them for the referral? Y N

PERSON RESPONSIBLE FOR PAYMENT (IF NOT YOU): \_\_\_\_\_ Relationship: \_\_\_\_\_

Billing Address with City/Zip Code: \_\_\_\_\_

Contact #: \_\_\_\_\_ Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

**INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)** Is condition result of an accident? Y N

If yes, Date of Injury: \_\_\_\_\_ Type of Injury: Auto [ ] Work Related [ ] Other [ ] \_\_\_\_\_

Name of Case Manager: \_\_\_\_\_ Telephone number: (\_\_\_\_\_) \_\_\_\_\_

Primary: Insurance Company: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address of Ins Co: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary: Insurance Company: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address of Ins Co: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**SIGNATURE/AGREEMENT**

**I hereby give my consent for psychological consultation and treatment. I understand that Dr. Slaughter is an independent practitioner. I agree to be financially responsible for all charges for treatment and/or cancelled appointments as outlined in Dr. Slaughter's financial policy. I authorize the release of any medical, psychological, or other information necessary to process my insurance claims. I authorize payment of medical/psychological benefits directly to Dr. Slaughter.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_