William Collinge, PhD, LCSW

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CLIENT INFORMATION FORM

Today's date_____ Referred by_____

Name_____ Date of birth _____

Mailing address_____City_____Zip_____

Phone: Home_____ Work_____ Cell_____

Email address: _____Is email a good way to reach you?_____

Name of spouse or partner_____ How long together?_____

Children names and ages_____

Who to contact in emergency_____Phone_____

Are you employed? ☐ Yes ☐ No If yes, position_____

Name of your physician _____

Medical diagnoses_____

Currently in counseling or therapy? ☐ No ☐ Yes--where_____

What would you like to gain here?_____

_____

Payment information. How do you plan to pay for services:

☐ Insurance ☐ Visa ☐ Mastercard ☐ Health Savings Account ☐ Check ☐ Cash

If you have insurance, please contact your provider to determine your coverage for behavioral health (outpatient counseling or psychotherapy) with a licensed clinical social worker (LCSW), number of sessions, and deductible or co-pay amounts.

Insurance plan _____Member ID#_____

Number of sessions allowed_____ Co-pay if applicable_____

Please return this form by email to william@collinge.org, fax (207) 510-8060, or mail (address above).

THANK YOU!