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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!