**IDEAL LIVING PSYCHOLOGY CENTER, INC.**

# CLIENT FACE SHEET

(Please Print)

| ❑ The subscriber is NOT the same as patient. | Date of Initial Visit: |
|---|---|

## PATIENT INFORMATION

| Patient's Name: First: Last: | ❑ Mr.<br>❑ Mrs. | ❑ Miss<br>❑ Ms. | Marital status (circle one)<br>Single / Mar / Div / Sep / Widow |
|---|---|---|---|

| Is this the name on your insurance plan?<br>❑ Yes ❑ No | If not, what is the name on your insurance plan?<br>❑ n/a | ❑ Email ok for non-clinical info. | Birth date:<br>/ / | Age: | Sex:<br>❑ M ❑ F |
|---|---|---|---|---|---|

| Home Phone Number: | Cell Phone Number: | Minor? ❑ Yes ❑ No<br>Parent/Guardian: |
|---|---|---|

| Patient address: | City: | State: | Zip: |
|---|---|---|---|

| Occupation: ❑ Employee ❑ Student<br>Title/Grade: | Employer Name/School Name: | Employer City/School City: |
|---|---|---|

| Referred to therapist by (please check one box): | ❑ Magazine Advertisement | ❑ Other Tx Provider | ❑ Hospital |
|---|---|---|---|

| ❑ Family | ❑ Friend | ❑ Company Website | ❑ Psychology Today | ❑Insurance Plan |
|---|---|---|---|---|

Referral Name (if appropriate):

## INSURANCE INFORMATION

❑ The subscriber is the same as patient

| Subscriber's Name: | Birth date:<br>/ / | Subscriber's Address: | City, State, Zip: |
|---|---|---|---|
| Subscriber's Phone Number: | | Insurance Company: | Insurance Company's Phone Number: |
| Subscriber's Employer: | Pre-auth required?<br>Yes ❑ No | Claims Address: | City, State, Zip: |
| Member ID: | Co-payment amount? | Policy Group: | Plan Name: |
| **Does the patient have EAP?**<br>❑ Yes ❑ No | **# of visits:** | **EAP Group Plan Name:** | **EAP Group Phone Number:** |

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | **EAP Auth #:** |
|---|---|---|---|---|

❑ **Insurance information has been verified by a representative of this office.**

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.:<br>( ) | Cell phone no.:<br>( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. Even if I intend to use insurance, I understand that I am financially responsible for all fees for treatment. I authorize Ideal Living Psychology Center and my insurance company to release any information required to process my claims. I also understand that my insurance carrier may elect to audit my record and therefore is not guaranteed to remain confidential.

*Patient/Guardian signature* *Date*