Psychological Associates of Schuylkill County LLC

Client Data Sheet

(Procentive)

Date: _____ Date of first illness/problem (if known): _____

(**Please print legible** and be sure to fill the bolded sections of this form)

Name: _____ ___ _____
(first) (MI) (Last)

Address: _____

_____

City/Town: _____ **State**: _____ **Zip**: _____

Email Address: _____(Primary)

_____ (Alternate)

Date of Birth: _____ **SS#**: _____

Gender: ☐Female ☐ Male
☐ Other _____

Marital Status: ☐Single ☐Married ☐Divorced/ ☐Widow(er) ☐Partner

Phones:

_____ ☐Home: ☐Cell: _____ ☐Home: ☐Cell:
☐Work: ☐Other ☐Work: ☐Other

_____ ☐Home: ☐Cell: _____ ☐Home: ☐Cell:
☐Work: ☐Other ☐Work: ☐Other

If Client a Minor: Parents Names: _____ _____
(☐mother ☐father) (☐mother ☐ father)

Address/Phone (if not same): _____ _____

_____ _____

Employment: ☐Not ☐Full-time ☐ Part-time ☐Self
☐Retired ☐Military ☐Disabled

Student: ☐Yes ☐ No
☐Full-time ☐Part-time.

Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to specify

Emergency Contact: _____ Relationship: _____

Phone: _____

Do you want appointment reminders: ☐Yes ☐No If yes how delivered, ☐SMS ☐ Email (check only one)

Primary Care Physician: _____ Phone: _____

Address: _____

_____

Permission to speak with PCP
☐Yes ☐ No

Client Name: _____

Referral source/Who referred you: _____

Is the visit due to a motor vehicle accident ☐or work-related injury ☐? ☐Yes ☐ No

If Yes, check appropriate box and note date of accident/injury and insurance: _____

Claim Number: _____ Insurance Information: _____

Insurance Information:

Name of Insurance: _____

Employer: _____

Subscriber: _____ Subscriber SS#: _____ DOB: _____

Relationship: _____

Insurance ID Numbers: _____ Group: _____

Secondary Insurance: ☐Yes ☐ No Name: _____ ID#: _____

Subscriber: _____ Subscriber SS#: _____ DOB: _____

If patient is a child and is covered by both parents, which birthdate is closest to January 1st? _____

EAP Information: ☐Yes ☐ No
Authorization #: _____ # of sessions: __ Phone #: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Psychological Associates of Schuylkill County, LLC and the providers within for the services rendered to me or my child while under the care of that office/program. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have. If for some reason, my account should become delinquent, I agree to pay for all collection and legal fees.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical information necessary to process my claims for Psychological Associates of Schuylkill County, LLC and the providers within the practice.

Signature: _____ Date: _____

Print Name: _____ Relationship: ☐Client ☐Parent ☐Guardian.

To be completed by Counselor:

		Default	Active	Inactive	Date
Program:	Mental Health:	☐	☐	☐	_____
	Psychological Testing:	☐	☐	☐	_____
	Forensic:	☐	☐	☐	_____
	Group:	☐	☐	☐	_____