CLIENT DATA FORM

Directions, a Center for Life Strategies, LLC   20 Community Pl – 4th floor, Morristown, NJ 07960
Tamsen Thorpe, Ph.D., Director   Psychologist License #3826

CLIENT INFORMATION:

Office Use Only: Entered ____/____/____

Name: ______________________________________ Home Phone: (   ) _______-___________
Address: ______________________________________ Work Phone: (   ) _______-___________
City: __________________________ Zip __________ Cell Phone: (   ) _______-___________
Emergency Contact Name/Relationship: ______________ Emerg Phone: (   ) _______-___________

Email: _________________________________ Can we email you including our newsletter? ☐ Yes ☐ No

Date of Birth: ______/______/______

Soc. Sec. #: ________-______-_______   Sex: ☐ Male ☐ Female

Future communications such as a newsletter and/or event announcements may be sent to your email and/or street address. Check the following box only if you wish to opt out ☐.

Marital Status:	**Employment Status:**	**Is Client's Condition Related To:**
☐ Single	☐ Employed	Employment? ☐ Yes ☐ No
☐ Married	☐ Full Time Student	Auto Accident? ☐ Yes ☐ No Which State: _______
☐ Other	☐ Part Time Student	Other Accident? ☐ Yes ☐ No

Referral: ☐ Ins. Co. ☐ Physician ☐ Employer ☐ Therapist ☐ Friend
Specify name: ____

PAYMENT METHOD: ☐ Self ☐ Insurance (Complete below)

INSURANCE INFORMATION: (Please have your card ready for photocopy)

Insurance Co. Name: ____________________________________

Mental Health Phone: ____________________________________

Claims Address: ____________________________________ City: _____________ Zip __________

Does your insurance plan require pre-authorization/certification? ☐ Yes ☐ No

If yes, please provide authorization/certification number for initial sessions and quantity of sessions:

____

Is this policy through a place of employment? ☐ Yes ☐ No

If yes, name of employer: ____

Policy Holder (If different than patient): ☐ Spouse ☐ Parent ☐ Other ____________

Name: _____________________________________

Birth Date: ______/______/______

Soc. Sec. #: _______-_____-_______

Many insurance plans require that I ask if you would like clinical information sent to your primary care physician
☐ No, please do not send information. ☐ Yes, please send information. (Please fill out and sign release form)