

CLIENT DATA FORM

Directions, a Center for Life Strategies, LLC
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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: Single Married Other
Employment Status: Employed Full Time Student Part Time Student
Is Client's Condition Related To:
Employment? Yes No
Auto Accident? Yes No Which State: _____
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)