Susan Hoover, MSW, LISW
CLIENT INFORMATION FORM

Date________________

Name_____________________________________ Date of Birth________ Age_____

Address____

City/State____ Zip code_______________

Phone (Cell)_________________(Home)_______________ (Work)__________________
Ok to leave message? ____

Email Address __________________________________ OK to email _____

Social Security Number _________________________

Employer / School ____

Marital Status:
__ Never Married __ Married __ Divorced __ Separated __ Widowed __ Other

INSURANCE INFORMATION

Insurance Company ____

Member ID#______________________________ Group # _________________________

Name of Benefit Holder (if different from client)__________________________________

Benefit Holder DOB________________ Relationship to Client ____________________

Benefit Holder's Employer ____

Claims Address____

Phone _____________________________

Authorization # (if required) __________________________

Copay Amount ______________

Referral Source: ____

Family Members:
Name Birth Date Age Relationship
____
____
____
____
____

What concern brings you to counseling?
____
____
____

What changes do you want to see as a result of counseling?
____
____
____
____

EMERGENCY INFORMATION

Emergency Contact:__________________________________ **Phone**____________________

Relationship to Patient____

MEDICAL HISTORY

Currently under doctor's care? Yes No Date of last Physical Exam:______________

Doctor(s) involved in your care:____

Name of your Primary Care Physician:____

Address:____

Phone Number:____

Health problems (including allergies):____

Medication currently using: (if none, state none)
Medication Dosage Doctor Prescribing Reason Prescribed
__________________ __________ ______________________ _____________________
__________________ __________ ______________________ _____________________
__________________ __________ ______________________ _____________________
__________________ __________ ______________________ _____________________

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency:
Date Reason Hospital

______________________ _______________________ _______________________________
______________________ _______________________ _______________________________
______________________ _______________________ _______________________________

PAST MENTAL HEALTH HISTORY

Prior Outpatient Therapy for Mental Health or Chemical Dependency- include previous practitioners, dates of treatment, previous treatment interventions, and response to treatment interventions (including responses to medications)

____
____
____
____

Susan Hoover, MSW, LISW
Clinical Social Worker
3200 Linwood Avenue
Cincinnati, OH 45226
513-321-5999

Authorization to File Insurance Claims

I hereby authorize Susan Hoover, MSW, LISW to release to my insurance company all information regarding my treatment, rendered to myself of my dependents, pertinent to insurance claims.

I hereby authorize payment of benefits directly to Susan Hoover, MSW, LISW for her professional services.

I understand that I am financially responsible for all charges not paid by my insurance company. I understand that copays required by my insurance company are to be paid at the time services are rendered.

____ ______________

Signature of Client (Parent or Guardian if Client is a Minor) Date

Cancellation Policy

I hereby understand that my appointment must be cancelled with 24 hour notice or I will be charged $50.00. Charges for missed appointments or for failure to cancel cannot be billed to insurance companies and the $110.00 fee is my responsibility.

____ ______________

Signature of Client (Parent or Guardian if Client is a Minor) Date

Susan Hoover, MSW, LISW
Clinical Social Worker
3200 Linwood Avenue
Cincinnati, OH 45226
513-321-5999

Consent to Treatment

I have received a copy of the Client's Rights and Responsibilities and a copy of the practice information guidelines, including the right of confidentiality.

I accept and understand these documents.

I voluntarily consent to psychological treatment.

Signature ____

Printed Name ____

Date of Birth ________________________________

Provider Signature ____

Date ______________________