

Couples Counseling of Amherst LLC

Marlene Meinelt LICSW, CST

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Amherst, MA 01002
413-345-2991
413-825-0081 Fax

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ Date of birth: _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral?
 Yes No
- If referred by another clinician, would you like for us to communicate with one another?
 Yes No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life-or-death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

HEALTH INSURANCE:

Name of Your Insurance: _____

Subscriber: _____ Subscriber Date of Birth: _____

Subscriber ID#: _____ Group #: _____
(On insurance card) (If on insurance card.)

Relationship to subscriber: _____ Self _____ Partner/Spouse _____ Child _____ Other (please explain)

For individuals who are on their parents/partners/spouses insurance plan, please enter the following information:

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Address: _____

Insured's Employer: _____

Please briefly describe your presenting concern(s): _____

I hereby authorize my insurance benefits to be paid directly to **Marlene Meinelt LICSW, CST** for services rendered. I also authorize **Marlene Meinelt LICSW, CST** to release any information necessary to process this claim.

Signature: _____

Date: _____