**LORI BOHNERT, LMHC**

PATIENT INFORMATION:

Client Name: ______________________________________ Today's Date: ______________

Marital Status:____________________ Spouse's Name: ___________________________________

Address: _____________________________________________________________________________

City: _________________________________ State:_______________ Zip Code: _______________

Home Phone: _________________ Work Phone: _______________ Cell Phone: _______________

Preferred number for us to use to contact you and leave a message: ________________________

Social Security #: ________________________ DOB: __________________ Age: _______________

Employer: ____________________________________________________________________________

Occupation: __________________________________________________________________________

Highest level of education received? ___________________________________________________

Primary Physician: ____________________________________________________________________

Name of Insured: ________________________________________ DOB: ______________________

Insured's Employer: ___________________________________________________________________

Insurance Company: __________________________________________________________________

Insurance Company Phone #: ________________________________ (mental health # or benefit)

Policy #: _________________________________ Plan/Group#: ______________________________

Who may I thank for this referral? _____________________________________________________

Emergency contact: ______________________________ Phone #: ___________________________

**I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE, FOR ALL FEES AND CO-PAYMENTS AND THAT IF I CANCEL AN APPOINTMENT WITHOUT 24 HOURS NOTICE OR FAIL TO ATTEND A SCHEDULED APPOINTMENT, I AM RESPONSIBLE FOR PAYMENT FOR THAT SESSION.**

_________________________________________ ____________________________

Signature of Client Date of Signature

_________________________________________ ____________________________

Parent / Guardian (if client is a minor) Date of Signature