Rich Morey, Ph.D. Licensed Psychologist--PSY. 12822

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CLIENT INFORMATION FORM

AME OF SUBSCRIBER/POLICY HOLDER: First			Middle			Last	
CIRCLE RELATIONSHIP OF CLIENT TO THE SU	BSCRIBER:	Self	Spouse	Child	Other		
DOB OF SUSCRIBER:/							
ADDRESS OF SUBSCRIBER:			,			, ,	
Address and Street			City		State	Zip	
HEALTH INSURANCE COMPANY NAME							
POLICY NUMBER:	bring to your	GROU	JP NUMBE on)	ER:			
PERSONAL			JP NUMBE on)	ER:			
PERSONAL			JP NUMBE on)	ER:			
PERSONAL NAME OF CLIENT		_					
POLICY NUMBER:	ALTERNA	— ATE PHON					
PERSONAL NAME OF CLIENT PRIMARY PHONE	_ ALTERNA	— ATE PHON	E				
PERSONAL NAME OF CLIENT PRIMARY PHONE CLIENT DATE OF BIRTH HOME ADDRESS:	_ ALTERNA	— ATE PHON —	E	CITY			
PERSONAL NAME OF CLIENT PRIMARY PHONE CLIENT DATE OF BIRTH HOME ADDRESS: (If different from above)	_ ALTERNA SPOUSE'S	 ATE PHON S PHONE ₋	E	CITY			
PERSONAL NAME OF CLIENT PRIMARY PHONE CLIENT DATE OF BIRTH HOME ADDRESS: (If different from above) SPOUSE'S NAME	_ ALTERNA SPOUSE'S	— ATE PHON — S PHONE _	E	CITY			

MEDICAL/PROFESSIONAL LIST CURRENT ILLNESSES AND RECENT SURGERIES CURRENT MEDICATIONS AND DOSEAGES _____ HOW MUCH DO YOU USE: TOBACCO? _____ ALCOHOL? ____ CAFFEINE? ____ LIST ANY PRIOR PSYCHOTHERAPY (type of treatment, provider, length of treatment, outcome) BRIEFLY DESCRIBE YOUR PRESENT DIFFICULTIES HAVE YOU HAD ANY HISTORY OF SELF-INJURIOUS BEHAVIOR, SUICIDAL IDEATION, OR SUICIDE ATTEMPTS? IF SO, PLEASE DESCRIBE. HAVE YOU HAD A HISTORY OF HARM/ABUSE AGAINST OTHERS? IF SO, PLEASE DESCRIBE.____ PHYSICIAN _____ PHONE _____ NEUROLOGIST _____ PHONE _____ PSYCHIATRIST PHONE ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES: REFERRAL SOURCE? I hereby apply for evaluation, treatment and other services offered to me by Rich Morey, Ph.D. I am aware that the practice of psychotherapy is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatment. As I completed the insurance information on page 1 this indicates that I am asking Dr. Morey to bill my insurance on my behalf. I am authorizing Dr. Morey to release the required information to process this claim and to have payment sent to Dr. Morey. Yet, even though Dr. Morey provides this billing service---I understand that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information on these two pages and have completed the above items. This information is true and correct to the best of my knowledge. I will notify Dr. Morey of any changes in my health, emotional status, or above information. Date Signature

Date _____

Parent (if patient is a minor)