Client Demographic Information Today's Date_____

Client's Name: _____ DOB: _____

Parent's Name(s) (if applicable)_____

Address: _____

Phone #s: Home: _____ Work: _____ Cell: _____

Ok to leave message: **Y N** **Y N** **Y N**

Employer & Location: _____

If I Need to Contact Someone about You: If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you – perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write the name and information of your chosen contact person in the spaces below:

Name: _____

Address: _____

Phone numbers: _____ Relationship to you: _____

Insurance Information: if we accept your insurance and you want us to bill your insurance company for services here, complete the following *IF DONNA HAS NOT ALREADY COLLECTED THIS:*

Insurance Co.: _____

ID #: _____ Group #: _____

Subscriber's Name (if not you): _____

Subscriber's Address (if not you): _____

Subscriber's DOB (if not you): _____ Relationship to you: _____

I request payment of authorized insurance benefits to be made on my behalf to: Gina Daniel, LCSW for services furnished to me by her. I authorize GLD or her employees to release to the Insurance Company and its agents any information needed to determine the benefits and reimbursement payable for services. I permit a copy of this authorization to be used in place of the original.

_____ _____

Your Signature ***Date***