

Elizabeth Scott, LMFT

MARRIAGE & FAMILY THERAPIST

543 Plumas Street | Reno, NV 89509 | Telephone: (775) 825-2503, ext. 105 | Fax: (775) 825-2503

NEW CLIENT INFORMATION

Client Information:

Legal Name _____

Preferred Name _____

Gender _____

Physical Address (required)

Cell Phone # (_____) ____ - ____ - ____

Marital Status _____

Emergency Contact Information:

Name _____

Cell Phone # (_____) ____ - ____ - ____

If Client is a Minor:

Parent/Guardian Name _____

Physical Address (required)

Cell Phone # (_____) ____ - ____ - ____

Additional Parent/Guardian Name _____

Physical Address (required)

Cell Phone # (_____) ____ - ____ - ____

Social Security #: _____ - _____ - _____

Date of Birth ____ / ____ / ____

Gender Identity _____

Mailing Address (if different)

Work Phone # (_____) ____ - ____ - ____

Employer _____

Relationship to Client _____

Work Phone # (_____) ____ - ____ - ____

Mailing Address (if different)

Work Phone # (_____) ____ - ____ - ____

Mailing Address (if different)

Work Phone # (_____) ____ - ____ - ____

Insurance Information:

Insurance Plan _____

Policy # _____

Policy Holder Name _____

Policy Holder Date of Birth ____ / ____ / ____ - ____

Policy Holder Address (required)

Policy Holder Employer _____

Group # _____

Policy Holder Social Security #: ____ - ____ - ____ - ____

Please indicate your referral source

Other Information to Consider:

Are you seeing any other therapists or a psychiatrist? If yes, please list below:

Please use the space below if you would like to provide any other information that will assist in your treatment or the treatment of the client, including but not limited to information about the party responsible for the client and payment for services.

Certification:

By signing below, I certify that this information is true and correct to the best of my knowledge. I will notify the provider of any changes in any of the information listed, including insurance changes. I authorize Elizabeth Scott to release any necessary information, such as diagnosis or service provided, to process my insurance claim and payment of benefits to my insurance carrier.

Client Name (please print) _____

Client Signature _____ Date _____

Client Name (please print) _____

Client Signature _____ Date _____

Parent/Guardian Name (please print) _____

Signature Parent/Guardian _____ Date _____