Center for Psychological Discovery

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KATRINA L. LOKKEN, Psy.D. | WHITNEY E. WOODCOX, Psy.D. | COURTNEY BARON, LPC | NICOLE ONORATO, LPC

Client Information Form

Date _____

Client's Name: Last _____First _____M.I.___

Client's Date of Birth: _____ Sex: M _____ F_____

Client's SSN:_____-_____-_____ *If client is a minor, name & relationship of responsible party:

Guardian's Name: Last _____ First _____M.I.___

Relationship to Client: _____ Single ___ Married ____ Divorced____

Street Address (No P.O. Boxes) _____

City _____ State _____ Zip _____

Home Phone( )_____ Cell Phone ( )_____

Work Phone ( ) _____ E-mail address: _____

May we call to confirm appointments? Yes_____ No _____ Emergency Phone ( ) _____

Primary Insurance Carrier _____ Policy / Group # _____

Insured's Name: _____Insured's Birthdate:_____

Insured's ID/SSN:_____-_____-_____ Insured's Employer: _____

Who referred you to our office? _____

I request that payment of authorized third party benefits be made on my behalf to Dr. Katrina L. Lokken, Psy.D., P.C., and the Center for Psychological Discovery, P.C. for any services furnished to me by her or her assistants. I understand my signature also authorizes release of any information contained in my records to any relevant insurer, or to its assignees, necessary to pay a particular claim. By my signature, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason.

_____ _____

Signature of Client or Responsible Party Date

286 SOUTH MAIN STREET, SUITE 200, ALPHARETTA, GA 30009

PHONE: (678) 820-8386 | FAX: (770) 234-5889