CHERYL BIAS, LCSW
LICENSED CLINICAL SOCIAL WORKER

Client Name (Please Print) | Marital Status | Date of Birth

S M W D Sep.

Street Address | City/State | Zip Code | Home Phone # | Cell Phone #

Client's Employer | Occupation (Indicate if Student) | How long employed? | Business Phone #

Employer's Address | City/State | Zip Code | Client Driver's License #

Best number and time to reach you: _____ E-mail _____

Education _____

In case of emergency, contact (name, relationship and phone number):

Who referred you to this practice? _____

May I have your permission to thank this person for the referral? _____ Yes _____ No

Primary Care Physician _____ Phone #: _____

Are you taking medications? _____ If yes, please list: _____

Spouse's Name | Date of Birth

Spouse's Employer | Occupation (Indicate if Student) | Business Phone #

Employer's Address | City/State | Zip Code

PRIMARY INSURANCE INFORMATION

Insurance Company Name | Policy Holder Name | Date of Birth

Insurance Company Address | City/State/Zip Code | Phone #

Group # | Insurance ID # | Effective Date

SECONDARY INSURANCE INFORMATION

Insurance Company Name	Policy Holder Name	Date of Birth
Insurance Company Address	City/State/Zip Code	Phone #
Group #	Insurance ID #	Effective Date

Have you ever been in counseling before? _____ If yes, please list the name of the therapist(s) you have seen and dates: _____

Why are you seeking therapy? _____

What goals do you have for therapy? _____

PAYMENT/CANCELLATIONS/CONFIDENTIALITY

Payment is appreciated at the time of each visit.

Cancellations: If you must cancel an appointment, please notify me 24 hours ahead of your scheduled appointment. Unless I am notified, you will be charged $65.00 (half of my $130.00 fee).

Confidentiality: All information shared in our session will be kept confidential unless you are determined to be a danger to yourself or others.

Please ask if you have any questions and thank you for completing this form.

I, _____, authorize the release of any medical information necessary to process this claim and the payment of medical benefits to **CHERYL BIAS, LCSW** and to Catherine J. Sasser, billing agent.

I understand and agree with the above information.

Signature:_____ Date:_____