Psychotherapeutic and Psychological Services
David H. Rademacher, MA LPA LPC NCP

Client Information

Welcome to my practice. I look forward to helping you achieve your goals. This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them.

Client's Name: _____
F First Initial Last Sex: (circle): M F

Address:
_____
Street City State Zip

Phone (H)_____ (W)_____ Birth Date: _____ Age _____

Cell/Mobile Phone: _____

E-Mail Address:_____

Employment/School: _____
Occupation/Year in school_____

Parent/Spouse/Partner's Name: _____
Parent/Spouse/Partner's Employer: _____

Emergency Contact:
_____
Name City State Zip
Telephone #_____

Who referred you?_____
Type of referral source: (MD, lawyer, client, therapist, ins. co, phone book, other)

Primary Care Physician/Treating Psychiatrist_____
Telephone #_____

*****HAVE YOU SEEN ANOTHER THERAPIST THIS YEAR? _____**
Number of visits used:_____

Office Location: 35 Thompson St., Ste 205 * Pittsboro, NC 27312 * 919.542.1726
Mailing Address: 7 Branch Street * Chapel Hill, NC 27516

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Insurance Information

Please provide a copy of your insurance card to the office staff or to your therapist

Please be advised that you will be responsible for payment should your insurance refuse to pay for services rendered

Primary Insurance Carrier (outpt. mental health) _____
Phone: (_____)_____

Policy Holder: _____ Relationship: (circle) self spouse child other_____

If not self, policy holder is: Circle: M/ F DOB:_____
Their employer _____

Insurance Policy #: _____ Group #: _____

Is the problem for which you are here related to: Employment? Y _____ N _____
Accident? Y _____ N _____

Person responsible for payment:
Name: _____

Address: _____ Phone: (H): _____
(W): _____

Plan for session payments: check _____ credit card _____ cash _____

IF USING INSURANCE: SIGN BELOW

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician or supplier for services below.

Signed _____ Date _____

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