Robert Forte, LPCC, Ltd. **Diag.: _____**

Confidential Client Information **(office use only)**

Today's Date_____

Name
(Please print)_____ Date of Birth_____ Age_____

Address_____ City_____ State _____Zip_____

Preferred phone_____ Other phone_____

Social Sec. #_____ Email_____

In case of emergency, please contact
Name_____ Relationship_____
Preferred phone_____ Other phone_____

Significant medical conditions_____
Current problem for which you seek
counseling_____

Referred by_____

<u>REQUIRED if you intend to use your insurance or EAP</u>
Name of your insurance company_____
Phone number of your insurance company_____
Insurance company billing address_____
Policy Holder_____ Subscriber ID number_____
Your relationship to policy holder_____
I authorize payment as outlined by my insurance company or EAP to Robert Forte, LPCC, Ltd.:

Signature_____ Date:_____

<u>Please read this form, print it and bring a completed copy to your first session. Thank you.</u>