Transforming Lives, Impacting the Future

Legacy Clinical Consultants, LLC

Client Information Form

Date _____

Client Name_____ Male/Female_____

Address_____

City _____ State _____ Zip _____ Home Phone _____

May we leave a message at your home phone? *(Please feel free to leave comments.)*

☐ Yes ☐ No_____

Date of Birth_____ Student Status: ☐ Full Time Student ☐ Part-Time Student ☐ Non-Student

Who referred you? _____ Phone:_____

Required Signature

I understand all payments and co-payments are due at the time service is rendered by check, cash, or credit card. I understand that unless paid in full at the time of service, I assign any insurance benefits accrued to me to **Legacy Clinical Consultants, LLC**. I understand I am responsible for payment regardless of whether I am reimbursed for those services. I understand if I fail to provide at least 24 hours advance notice of cancellation of a session, I am responsible for payment in full for the missed appointment.

Guarantor Signature: _____

This section pertains to children/adolescent clients:

School _____ Grade _____

Please indicate if we may leave messages at these numbers. *(Check One)* ☐ Yes or ☐ No and Initial here: ____

Parents in household:

Name_____ Day Phone_____ ☐ Y ☐ N

Cell Phone _____ ☐ Y ☐ N Evening Phone _____ ☐ Y ☐ N

Name_____ Day Phone_____ ☐ Y ☐ N

Cell Phone _____ ☐ Y ☐ N Evening Phone _____ ☐ Y ☐ N

Birth Parent not in household:

Name_____ Day Phone_____ ☐ Y ☐ N

Cell Phone _____ ☐ Y ☐ N Evening Phone _____ ☐ Y ☐ N

Siblings living at home or away:

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

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