Carrie Sheets, Ph.D.
Licensed Psychologist
Client Data Sheet

INSIGHT COUNSELING, LLC

Today's Date ___/___/___

Name_____
Last First Middle Initial

Home Address_____

City, State and Zip Code_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

E-Mail_____

Social Security Number _____ Birth Date ___/___/____ Age ____ Sex _____

***Insured_____ Insured's Employer_____

Will you submit insurance claims for reimbursement?_____ Insurance company_____

Billing Address (if different from above)_____

Employers Name _____ Your Position _____

Address_____ Years with Employer _____

Education (# of Years)_____ Highest Degree _____ Usual Occupation_____

Referred By_____

Others in your family or living in the home with you:

Name	Age	Relationship to you

In Emergency, Notify: (Please name two)

Name _____ Name _____
Address_____ Address_____
_____ _____
Phone_____ Phone_____
Relationship to you_____ Relationship to you_____

Family Physician: _____
Name Phone

_____
Address City State Zip

Your Signature_____ Date____/____/___

(This signature does not authorize release of information or obligate you in any way to InSight Counseling, LLC. or your Independent Practitioner. It is requested for your protection only)

***Regarding insurance: It is the responsibility of the client to file claims with their insurance company.
Your Practitioner does not maintain a supply of insurance forms. Payment is required at the time of service.

InSight Counseling, LLC is home to a network of Independent Practitioners.