
JULIE OHLINGER, MSW, LCSW

**Counseling for Individuals, Couples and Families
NEW CLIENT INFORMATION**

Name _____	Date _____
Address _____	Employer _____
_____	Start Date _____
_____	Occupation _____
Cell Phone _____	Marital Status _____
Email : _____	Date of Birth _____
Do I have permission to utilize this route to communicate with you? Yes _____ (initials) No _____ (initials)	
Referred By: _____	
May I thank the person who referred you to my practice? Yes _____ (initials) No _____ (initials)	

Type of Insurance: _____

Primary Cardholder Name _____ DOB: _____

Employer of Insured: _____

Primary Care Physician: _____ Phone _____

Do I have permission to contact this physician? Yes _____ (initials) No _____ (initials)

Psychiatrist: _____ Phone _____

Do I have permission to contact this physician? Yes _____ (initials) No _____ (initials)

Medications (Include prescription, non-prescription and herbals) _____

Spouse/SO _____

Emergency Contact:

Name _____ Phone _____

Your Goals in Therapy _____

FEE: \$225.00/Initial session, \$175.00/50 minute session. Payment or copayment is expected at time of session. If you are a fee-for-service client (no insurance), I will allow a provider adjustment/sliding fee based on need. I accept cash or checks only. Receipt of payment is available on request. Full session fee is charged if no show or cancellation within 2 hours of appointment time, partial fee of \$50 is charged if cancellation is made 2-23 hours prior to appointment. Insurance will not pay for this charge. I have a 24 hour message service available. If an overpayment is discovered, a prompt refund will be paid. You will be sent a bill for any unpaid balance, and prompt payment will be appreciated. I do not utilize collection services. (Initials) _____

INSURANCE: If you are using insurance for which I am a contracted provider, I ask you to sign the blank insurance claim form (CMS 1500) where highlighted. You need not fill out all of the information on the form. Your signature indicating your consent to file a claim and assign the benefits to me is a _____ that is needed. For non-contract insurance (out of network), I will provide a Super Bill for you to submit for your reimbursement.

Client Signature: _____ Initials: _____ Date _____



Witness: _____ Date _____

Client _____ Rev. 11.17.25

Therapist: Julie Ohlinger, LCSW-10266