JULIE OHLINGER, MSW, LCSW
Counseling for Individuals, Couples and Families
NEW CLIENT INFORMATION

Name _____ Date_____

Address _____ Employer _____
Start Date _____

_____

Occupation_____

Phone _____

Marital Status _____

Cell Phone _____

Date of Birth _____

Email :_____

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)

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

Spouse/Significant Other_____

Emergency Contact: Name_____ Phone_____

Your Goals in Therapy_____
_____

FEE: $175.00/Initial session, $125.00/50 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 all 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 _____

Mother Signature for Minor Client_____ Date _____

Father Signature for Minor Client_____ Date _____

Legal Guardian for Minor Client_____ ☐ Court Documents Received (if any) Date _____

Witness:_____ Date _____