CLIENT INFORMATION FORM

(Please sign this form and email to susan@susanodellphd.com

Date_____

Legal Name_____ Preferred Name_____

Date of Birth:_____

Pronouns Used: She/her; He/his; They/them (Please circle) Other Pronouns_____

Street Address_____ Email Address_____

City_____State_____Zip_____

Best Phone number to leave a message_____

Employment/Student Status/Occupation:_____

Place of Employment_____

Street Address_____

City_____ State_____ Zip_____

In case of emergency, please notify:_____

Relationship _____

Street Address _____

City _____ State _____Zip _____

Phone_____

Did someone refer you to Dr. O'Dell? Yes_____ Name_____ No_____

Authorization to Release Confidential Information to Your Insurance Company

Name of Member_____ Date of Birth:_____

I understand that the purpose of this release is to assist with my/this client's treatment by coordinating care with a third party payer/insurance company. I authorize Susan O'Dell, PhD to release the below specified information regarding me/the client to the party listed below and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by my initials below, and any items not be released have a line drawn through them.

_____Identifying client information ____Names(s) of treatment programs

_____Treatment plan _____Dates of appointments

_____Diagnosis _____Progress notes

_____Treatment summary

_____Compliance

_____Other:_____

This information can be disclosed to these third party payers/insurance companies:

_____ _____
Name of party/insurance company Name of party/insurance company

_____I authorize Dr. O'Dell to have a copy of my Health Insurance card in order to verify my benefits.

_____I understand that I am responsible for any treatment fees not covered by my insurance benefits.

_____ _____ _____
Signature of client Printed name Date