Jack Collins, MA, LCMHC
Licensed Clinical Mental Health Counselor
603-393-8876
211 South Main St. Laconia, NH 03246

CLIENT INFORMATION SHEET

Date_____ Name_____ Age_____ DOB____/____/____

Address_____ City_____ State ____ Zip_____

SS#_____ Marital Status_____ Home phone_____

Cell Phone #_____ Occupation_____

Work #_____ Employer_____ Address_____

Insurance Company_____ Address_____

Subscriber_____ ID #_____ Group #_____

Spouse Name_____ DOB_____/_____/_____

SS #_____ Occupation_____

Employer_____ Insurance Company_____

Referring person_____

Names and Ages of Children_____

Family Physician_____ Address_____ Phone_____

Medications currently taking_____

Hospitalizations_____

Briefly state why you came today: _____

Billing Authorization:
I authorize Jack Collins to furnish sufficient information to insurance carriers to process my claims and assign payments for all services rendered. I am responsible for any amount not covered by my insurance, unless otherwise specified by contractual agreement. Since time is reserved exclusively for me, there is a session charge for missed appointments and cancellations less than 24 hours in advance.

Signature _____ Date _____