INFORMATION SHEET
LINDA WEINER, MSW

CLIENT NAME _____ Date _____

Address _____ City/State _____ Zip Code _____

CONTACT INFORMATION – CLIENT

Telephone - Home _____ Cell _____ Email _____

Date of Birth _____ Age ____ Religion _____ Highest Education Level Completed _____

Occupation _____ Employed By _____

Address _____ City _____ Zip Code _____

Please Check: Single ☐ Married ☐ Coupled ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ☐

SPOUSE/PARTNER(S)/PARENT NAME _____ D.O.B. _____

Years Married/Coupled _____

Spouse/Partner Occupation _____

Partner's Cell Number _____ Partner's Email _____

Names and Ages of Children _____

Current Medical Problems (client) _____ (partner) _____

Current Medications (client) _____ (partner) _____

Name of Referral Source _____
May I send a thank you note to referral source? Yes _____ No _____

Name of Primary Physician _____

Name(s) of previous Psychotherapist(s) _____

Insurance Information – Please list your health insurance company(ies)

Primary Policy Name	Phone No.	Name of Insured	ID No.	Group No.
Secondary Policy Name	Phone No.	Name of Insured	ID No.	Group No.

Payment: Payment is requested at each appointment. My fee is $250 per 45 minutes. If you want to pay via PayPal or Venmo, there will be a service fee added. If requested, a statement will be sent to you by the 10th of each month reflecting services and payments for the preceding month. A finance charge of 18% per month may be applied to unpaid balances after 30 days. In the unlikely event your account is sent to collection, attorney fees and other costs of collection will be added.

Release: I agree to the release of information requested by my insurance company or Health Savings Account such as diagnosis and treatment goals in order to facilitate reimbursement for, or continuation of therapy services. _____ (please initial)

Please Note: If you are unable to keep any appointment, kindly give *24 hours* notice, otherwise a charge may be made for the time reserved.

Signature _____

Spouse/Partner Signature _____