MARSHALL CLINICAL & FORENSIC PSYCHOLOGY, LLC

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CLIENT INFORMATION

Adult clients please complete pages 1 and 3 only. Minor aged clients need all three pages completed by parent/guardian

(Please Print Legibly)

Full Name _____

Home Address _____

City, State, Zip Code _____

Home Phone: _____ Cell Phone: _____Work Phone _____

*Please note that I may need to leave a general message on any of the numbers provided unless otherwise directed. These messages will not include confidential healthcare information. If you do not want me to leave voicemail messages at a specific number, please indicate below. However, you must permit me to leave voicemail messages on at least one phone number.

Please do not leave voicemail messages at the following numbers_____

Male_____ Female_____ Birth Date _____ ***Last Four SSN #_____**

School (for children) _____ Grade_____

Marital Status: ___ Single ____Married ____Divorced _____ Separated _____ Other

Employer _____ Occupation: _____

***Emergency Contact _____ *Phone # _____**

Relationship to Patient_____

Referred By: _____

Fields marked with * must be completed
PARENT/Guardian INFORMATION (Information for each parent/guardian is required if patient is under 18 years of age)

Full Name _____

Relationship to Patient: ____ Mother _____ Father _____ Other

***Custody Status: LEGAL _____ sole _____ joint PHYSICAL _____sole ____ joint**

Home Address _____

City, State, ZIP _____

Home Phone: _____ Cell Phone_____ Work Phone _____

Date of Birth: _____ Social Security Number _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated

Employer_____ Occupation_____

Full Name _____

Relationship to Patient: ____ Mother _____ Father _____ Other

***Custody Status: LEGAL _____ sole _____ joint PHYSICAL _____sole ____ joint**

Home Address _____

City, State, ZIP _____

Home Phone: _____ Cell Phone_____ Work Phone _____

Date of Birth: _____ Social Security Number _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated

Employer_____ Occupation_____

Items with * must be answered. For separated/divorced parties, copies of court orders may be requested to confirm custody status.

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

PCP/Pediatrician _____

Office Location: _____

Office Phone: _____ Office Fax: _____

PSYCHIATRIST INFORMATION (if applicable)
Psychiatrist _____

Office Location: _____

Office Phone: _____ Office Fax: _____

For non-attorney retained cases
PROCESSING PAYMENT
I authorize Jennifer L. Marshall, PhD to handle all billing related matters and to generate invoices. I authorize payment to Marshall Clinical & Forensic Psychology, LLC for all services rendered. I understand that Marshall Clinical & Forensic Psychology, LLC will engage in collection activities and or civil suit against me should payment not be received.

Signature of Client/Guardian _____

Printed Name of Client/Guardian_____

Date:_____