Karen Campbell, LCSW-R

Patient Name:_________________________________ D.O.B. ____________
Address: ____

____

____

Cell Phone:________________________________
Home Phone:______________________________
Work Phone:_______________________________

Health Insurance:__________________________ ID #:_________________

Are you the primary Insurance prescriber? Yes ___ No ____
If No complete subscriber info:
Subscriber Name: ____
Subscriber D.O.B _____-_____-________
Subscriber Address: ____
____
____

Emergency Contact (s): ____

Phone:_________________________ Relationship to you:________

Phone:_________________________ Relationship to you:________

Referred By:____

By signing below I give my informed consent for psychotherapy and acknowledge receiving written notice of:

- Informed Consent
- Privacy Practices & Patient's Rights

________________________________ _____________________

Signature Date

Parent or Guardian _____________________________ Date ______

Parent or Guardian _____________________________ Date ______