PSYCHOLOGY CENTER 7441 '0' STREET, SUITE 402 LINCOLN, NE 68510
TEL: 402-483-4215 FAX: 402-483-5228

PERSONAL DATA RECORD

Client Name **D.O.B.**

Address Zip Home Phone #

Employer Work Phone # Cell Phone #

Spouse/Significant Other D.O.B. Home Phone #

Employer Work Phone # Cell Phone #

Primary Insured's Name, D.O.B., Social Security # **Health Insurance Co. & Member ID**

Emergency Contact Person : Name & Phone # Highest level of education completed:

M ___D ___S ___W____ _____ Self_____Spouse_____
Marital Status # of Yrs Married

Children: Name D.O.B. Name D.O.B.

Name D.O.B. Name D.O.B.

If Client is under age 19: _____
Mother's Name & Phone #

_____
Father's Name & Phone #

Referred by **Primary Care Physician**

Previous Counseling (when and with whom)_____

Medication Currently Using_____

_____
Prescribing Physician

Please initial any of the following to indicate your authorization for me to contact you via telephone:
Home_____ Work_____ Answering Machine_____ Voicemail_____ Work Voicemail_____
Preferred Email: _____

Please initial each space following the terms you agree to:

Signature below is: consent for treatment_____ permission to submit service charges to health insurance company_____agreement to pay unreimbursed expenses_____acknowledgment of receipt of the Nebraska HIPAA Notice Form_____.

Client Signature_____ _____
Date

Parent/Guardian Signature:_____ _____
Date

Please read and sign the Nebraska HIPAA Information Form