Radka Chapin, MA, MSW, LICSW

Client Information Form

Date: _____ Referred by: _____

Full name: _____

Age: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Work phone/home phone: _____

Email: _____

Okay to leave messages on (check all that apply): ☐ Cell phone ☐ Work/home phone ☐ Email

Emergency contact: _____ Phone: _____

Relationship to you: _____

Primary care physician and phone: _____

Do you plan on using medical insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of insurance company and plan: _____

Name of policy holder: _____ Policy holder DOB: _____

Relationship to patient: _____ Employer of policy holder: _____

Personal ID number: _____ Group number: _____

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand, however, I am responsible for any balance due prior to a decision to stop.

Client signature: _____ Date: _____