Clarity Psychological Services, LLC
9500 Brooktree Rd Suite 207
Wexford, PA 15090
412-628-2818

Client Information Form

Name: _____

Address: _____

City: _____ **State** _____ **Zip:** _____

Phone: May we identify ourselves when we call? Yes/No {Circle One}

Day: _____ **Evening** _____ **Cell** _____

Date of Birth: _____

Insurance Information

Primary Insurance Name _____

Policy Holder Name _____

Policy/Member ID# _____ **Group#** _____

Relationship to Insurance Holder _____ **Date of Birth** _____
Self, Spouse, Child, Other **Insurance Holder**

Secondary Insurance Name _____

Policy Holder Name _____ **Date of Birth** _____

Policy /MemberID# _____ **Group#** _____

I give my permission for Clarity Psychological Services, LLC and its authorized associates to submit all therapy sessions to my insurance company and release any medical records to the insurance if necessary. I understand that I may be responsible for any sessions my insurance doesn't cover. 48 hour notice is required for cancellations with the exception of an emergency situation or a fee may be charged for the missed session.

Signature _____ Date _____