Linda R Thorpe, LCSW, LLC 174 West St., Ste 108, Litchfield, CT 06759

Please fill out (each client) as completely as possible and SIGN where indicated.

NAME:_____ TODAY'S DATE :___/___/____

MALE/FEMALE/NON-BINARY AND PREFERRED PRONOUN:_____

DATE OF BIRTH__/_____/___AGE:_____

ADDRESS: _____

TELEPHONE: CELL:_____ HOME: _____

EMAIL:_____

FOR CONFIDENTIAL MESSAGES: IF SAME AS ABOVE, WRITE, "SAME AS ABOVE"

PHONE:_____EMAIL:_____

PERSON AND PHONE NO. TO CALL IN EMERGENCY:_____

HOW DID YOU HEAR ABOUT ME?_____

PRIMARY CARE PROVIDER_____

ADDRESS: _____PHONE: _____

INSURANCE INFORMATION

INSURANCE CO:_____INSURANCE ID#_____GROUP#_____

INSURED'S NAME:_____INSURED'S DATE OF BIRTH_____

I authorize Linda R Thorpe, LCSW, LLC to release information needed to obtain mental health Benefits. I understand that I can rescind this authorization at my request, should I make other arrangements for payment of services rendered.

SIGNED_____DATE_____

- ***Please be aware that I do not participate with all insurance companies. Let me know if you have any questions about this.***
- ***If you are in crisis and cannot wait for a return call, please call 911 or go to your local hospital emergency room.***
- ***You will be billed for the cost of your session for any missed appointments without giving at least 24 hour notice.***

SIGNED_____DATE_____

HIPAA Notice Form: I am required by Federal Law to provide you with the attached HIPAA Notice. Please sign to acknowledge receipt of this form.

SIGNED_____DATE_____