LITA W. RUSSELL, Ph.D. Licensed Psychologist
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CLIENT INFORMATION FORM

Name:_____
First Middle Last

Address:_____ Cell: _____
Street

_____ Home/Work Phone: _____
City State Zip

Birthdate: _____ Age:_____ Email: _____

If Adult - Marital Status: _____
Place of Employment:_____

If Child/Adolescent - Current School:_____ Grade: _____
Parent or Legal Guardian:_____ Date of Birth_____
Address: _____ Phone: _____
Parent or Legal Guardian:_____ Date of Birth_____
Address:_____ Phone: _____

Referred By: _____
May I contact this person to thank them for referring you? _____

PAYMENT INFORMATION

Responsible Person: _____

Primary Health Plan: _____ Phone: _____
Policy/ID #: _____ Group #: _____
Policy Holder: _____

Other Health Plan:_____ Phone: _____
Policy/ID #: _____ Group #: _____
Policy Holder: _____

RELEASE

I authorize Lita W. Russell, Ph.D., or her agents, to release information to any third party payor reimbursing her for the cost of these health services and assign all third party payments to Dr. Russell. I understand that I am responsible for all fees and charges, regardless of whether they may be reimbursed by a third party. I agree to pay my fee at the time of each session.

Signature: _____ Date: _____