Yumiko Kodama, LCSW
Psychotherapy

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Client Information

Please print clearly and fill in this sheet completely. Thank you.

Today's Date: _____

Client's First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Cell): _____

Date of Birth: _____ Age: _____ Gender: □ F □ M Marital Status: _____

Email Address: _____

Name of Parent/Guardian/Spouse: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Parent/Guardian/Spouse: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____ **SSN:** _____

Employment Information (If client is a child, use parent's employment)

Employer: _____ Position: _____ City: _____ Phone: _____

Employer: _____ Position: _____ City: _____ Phone: _____

Insurance Information (Primary)

Subscriber's Name: _____ DOB: _____ SSN: _____

Insurance Carrier: _____ Policy or ID #: _____

Insurance Telephone #: _____ Group #: _____

Insurance Address: _____

Insurance Information (Secondary)

Subscriber's Name: _____ DOB: _____ SSN: _____

Insurance Carrier: _____ Policy or ID #: _____

Insurance Telephone #: _____ Group #: _____

Insurance Address: _____

Signature of Person Responsible for Payment X _____ **(Must be signed for services to begin)**

Client/Person Responsible for Payment – I authorize the release of any medical or other information "necessary" to process this claim. I also authorize payment of medical benefits to the undersigned provider for services rendered. Insurance company will be billed as a courtesy. Patient is liable for payment of all medical health services rendered.

Person to contact in case of emergency:

Name _____ Relationship _____ Phone _____

Physician: _____ Phone _____ City & State _____

Referral Source: How did you hear of Yumiko Kodama, LCSW (or from whom)? _____