

Lorraine T. Giardino, Ed.D., LPC, NCC, CCMHC

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CONFIDENTIAL CLIENT INFORMATION FORM

Date _____ Soc. Sec. _____
Name _____ Age _____ Birthdate _____

Home Address _____

Employment _____

Marital/Partnership Status: Single Divorced Widowed Married Partnered

Name of Spouse/Partner _____

Phone number _____ Emergency Contact _____

Phone _____

Initial below:

_____ **I consent to entering treatment with Lorraine T. Giardino, Ed.D., LPC, NCC, CCMHS**

_____ **I do/not not (choose one option) agree to have information, pertinent to treatment and outcome released to my primary physician**

_____ **I understand that information may be given to my insurance company in order to facilitate billing and verification of insurance**

_____ **I agree to make any co-insurance payments required by my policy at the time of services and understand that I may be billed for sessions that are not cancelled prior to 24 hours.**