

Willowdale Counseling Center, PLLC  
322 Amherst Street  
Nashua, N.H. 03063  
(603) 881-7554

**Client Information Sheet**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ OK to leave msg.? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Psychiatrist/Prescribing MD/APRN: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Insurance Information (if applicable):**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

DOB of Insured: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Other insurance coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Name of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Release and Payment Authorization:**

By signing below I authorize the release of my medical or other information necessary to process claims for payment of services provided by the Willowdale Counseling Center, PLLC staff to the insurance company named above

\_\_\_\_\_  
Client or Authorized Person's Signature

\_\_\_\_\_  
Date

By signing below I authorize payment of benefits to Willowdale Counseling Center, PLLC.

\_\_\_\_\_  
Client or Authorized Person's Signature

\_\_\_\_\_  
Date