BRIGHT SOUL
COUNSELING & WELLNESS
FIND YOUR INNER LIGHT (AGAIN).

Client Information Form

Date: _____ Birthdate: _____
Name: _____
Address:_____
City: _____State: _____Zip:_____
Home Phone: _____ Cell Phone: _____

Spouse/ Significant Other:

Name:_____
Address:_____
City: _____State: _____Zip:_____
Home Phone: _____ Cell Phone: _____

Parent/ Guardian (for children):

Name:_____
Address:_____
City: _____State: _____Zip:_____
Home Phone: _____ Cell Phone: _____

Employer/School:

Occupation:_____
Address:_____
City: _____State: _____Zip:_____
Phone: _____ Can you be contacted at work?___Yes___No

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Primary Insurance: (If not using insurance, leave blank.)

Name:_____

Address:_____

City:_____State:_____ Zip:_____

Main Phone: _____ Mental Health Phone: _____

Subscriber Name:_____ Subscriber DOB: _____

Employer:_____ID#:_____Group #:_____

Secondary Insurance:

Name:_____

Address:_____

City:_____State:_____ Zip:_____

Main Phone: _____ Mental Health Phone: _____

Subscriber Name:_____ Subscriber DOB: _____

Employer:_____ID#:_____Group #:_____

Emergency Contact: _____, authorize Taryn Buffolino, LPC to contact the following person(s) if she is unable to reach me in an emergency:

Name: _____ Relationship:_____

Home Phone:_____ Work/Cell Phone:_____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notification to my therapist's office address. I understand that a revocation is not effective to the extent that my therapist has taken action in reliance on this authorization. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

Client Signature _____ Date_____

Therapist Signature _____ Date_____