Tania Davidson, Psy.D., A Psychological Corporation
143 Figueroa Street, Suite 7
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(805) 628-2613
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Corte Madera, CA 94925
(415) 347-3438

Client Information

Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with your clinician. All information is CONFIDENTIAL.

Your Name (First, Middle Initial, Last)

____

Preferred Pronouns: ____

Address____

City/State/Zip____

Phone #s: Home ____

Work____________________________ **Cell:** __________________________ **Ok to text?** __________

Email :_________________________________**Ok to Email Statements/Invoices?**_______________

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No____ **Yes**____ **(If Yes, please be specific)** ____

Age_________ **Birth Date**________________ **Social Security #** ______________________________

Occupation____

Employer____

Single____ **Married**____ **(# years**_______**) Partnered**____ **(# years**_______**) Separated**____ **Divorced**____

Widowed____ **Other**____ **(specify)**____

Names and ages of children____

____

Spouse's/Partner's Name____

Age________

Spouse's/Partner's Occupation____

Significant medical problems you have or had_______________________________________

____

Current Physician: ______________________________ **Phone #** _______________________

Current medications you are taking____

____

If you have had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

____

____

____

If you are currently working with any mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

____

____

____

If Using Medicare:

Member ID #________________________________

Social Security # ______________________________

(Dr. Davidson will take a copy of your card at the first session)

SIGNATURES

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information my clinician as soon as possible.

____   ________________________

Client Signature   **Date**

CLIENTS USING INSURANCE ALSO SIGN IN BOTH PLACES BELOW
I authorize the release of any clinical, benefits or other information between Tania Davidson, Psy.D., or my clinician and my insurance company/companies that is necessary to process insurance claims for me or my dependents. Clinical information may include current and/or past symptoms, previous mental health treatment, diagnosis/diagnoses, treatment plan and/or goals, progress reports, copies of clinical notes or other clinical information.

I authorize payment of health insurance benefits to Tania Davidson, Psy.D., A Psychological Corporation. for services provided. I understand that I am responsible for knowing my insurance coverage, and am ultimately responsible for all payments, including copays or other uncovered services.

____   _______________________________
Client Signature   **Date**

For co-payments and/or services not covered by insurance, the following information is needed:

Client Name: ____

Name on Card: ____

Date: ____

Type of Card: VISA ❐ MasterCard ❐ Exp. Date: _____/______

Card Number: _______________-_______________-_______________-_______________

Verification/Security Code (3 digit code on back of card by signature line):_______________

Billing Address:____

City:_______________________ State: ____________________ Zip:________________