Michael I. Vickers, PhD, LMFT
Family Development Associates
40 Speen St., #106
Framingham, MA 01701
508-877-3660 ext. 6
fax 508-872-6330 email: m-vickers@comcast.net

Client Information Sheet

Family Name ______________________ Date ____________

Address ______________________ Phone (h) __________

City ______________State _____ Zip __________ Phone (w) __________

Client # 1 ______________________ Date of Birth ____________

Client # 2 ______________________ Date of Birth ____________

Client # 3 ______________________ Date of Birth ____________

Referred by ______________________ Phone ______________

Reason for referral: ______________________

Email address: ______________________

Insurance Information

Name of insurance company ______________________

Insurance ID # ______________________ Group # ______________

Subscriber's Name ______________________ Employer ______________

Annual Out-patient mental health benefit __________ Am't used this year to date __________

Deductible ______________ Co-payment per session ______________

Pre-certification done? _______ Authorization # __________ Sessions granted? ___

Insurance Company contact phone # (mental health benefits) ______________

Insurance Company claims mailing address: ______________________

Authorization to provide services & responsibility for fees: I understand that I am responsible for all fees. If I am requesting that you access my health insurance benefits: I accept responsibility for all fees not directly paid by my health insurance; I accept responsibility for contacting my insurance company and meeting all of their requirements; and, I authorize release of information, including behavioral health questionnaire responses, to my insurance company. I understand that should I (or either of us) call you to appear before any legal proceeding, I will be responsible for personally paying fees charged for your time.

______________________ ______________________
Name Signed

______________________ ______________________
Name Signed

***Notice of Privacy & Confidentiality Policies received*:** __________ __________
Initials Initials