David Udelf & Associates
Psychological Services

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CLIENT INFORMATION

Client Name: First_____ Middle____-_____ Last_____ Date_____

Address: Street_____ City_____ State_____ Zip_____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Email Address_____ Employer_____

Birth Date_____ Age_____ Gender_____ Social Security #_____-_____-_____

Marital/Relationship Status: Single___ Married___ Separated ___ Divorced___ Widowed ___

Names and ages of all children in the family: _____

_____

Who Referred You to Becker, Udelf, and Associates? _____

Parent/Guardian Information (for Minors Only)

Father's Name: _____ Phone: Home (___) _____Work (___) _____Cell (___) _____

Father's Address: Street _____ City_____ State ___ Zip _____

Father's Email: _____ __Father's Employer: _____

Mother's Name: _____ Phone: Home (___) _____ Work (___) _____ Cell (___) _____

Mother's Address: Street _____ City _____State ___ Zip _____

Mother's Email: _____ Mother's Employer_____

Alternate Contact/Billing Information

If the name, address, or phone numbers you want us to use when sending bills or contacting you is different from the above, please indicate below. If the below is left blank, we will use the address and phone information provided above.

Billing Name: _____ Relation to Client: _____
Billing Address: Street _____ City _____State___ Zip _____
Phone Numbers for Alternate Contact: Home (___) _____ Work (___) _____ Cell (___) _____
Email for alternate Contact: _____
If you do not want us to leave a text, email, or a voicemail message, please indicate below how and where to leave a message.
_____

Person to Contact in Case of Emergency

Name: _____ Relation to Client: _____ Primary Phone: (___) _____

East Side Location
The Darwood Building
23360 Chagrin Boulevard
Suite 110
Beachwood, OH 44122

West Side Location
King James Office Park
24500 Center Ridge Road
Building 4, Suite 250
Westlake, OH 44145

Primary Insurance Information

Primary Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ DOB: _____

Policy Holder's ID #: _____

Policy Holder's Group #: _____

Claim Mailing Address: **BE SURE YOU HAVE CORRECT ADDRESS FOR MENTAL HEALTH CLAIMS**

Street_____ City_____ State___ Zip_____

Insurance Company ***Mental Health*** Phone Number: (___) _____

Deductible: $_____ Has deductible been met? _____

Copayment (amount you are responsible for at each visit): $ _____

Who will pay noninsured balance? _____

If you are required to get preauthorization for insurance coverage, have you done so? _____

Authorization #: _____ Number of Visits Authorized: ____ Effective Date: _____

Secondary Insurance Information

Secondary Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ DOB: _____

Policy Holder's ID #: _____

Policy Holder's Group #: _____

Claim Mailing Address: **BE SURE YOU HAVE CORRECT ADDRESS OF MENTAL HEALTH CLAIMS**

Street_____ City _____ State ___ Zip _____

Insurance Company Mental Health Phone Number: (___) _____

Deductible: $ _____ ___Has it been met? _____

Copayment (amount you are responsible for at each visit): $ _____

Who will pay noninsured balance? _____

If you are required to get preauthorization for insurance coverage, have you done so? _____

Authorization #: _____ Number of Visits Authorized: _____ Effective Dates: _____

My signature below indicates that I have provided accurate insurance information. Failure to do so will result in my being fully responsible for all charges.

Signature: _____ Date: _____