DEBRA K. SOWALD, PSY.D.
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INTAKE INFORMATION

PLEASE PRINT CLEARLY:

Client Name_____________________________________Age_____Sex_____________________

Birthdate__________Married_____Single_____Divorced______Widowed_________________

Address____

City__________________________State_______________Zip___________________________

Occupation:______________________Employed By___________________________________

Home Phone:___________________Work Phone:______________Cell Phone:_____________

Client's SSN:____________Emergency Contact Name:_________________Phone:________

Reason for Referral:____

Client Referred By:____

Financially responsible person (if different)__________________________________

____________Employed by____

Home Phone:____________________Work Phone:______________Cell Phone:____________

SSN:_____________Ohio Driver's License #:_____________________________________

ASSIGNMENT OF BENEFITS:

I hereby assign all psychological benefits, to include major medical benefits, including Medicare, private insurance, and any other health plan to Debra K. Sowald, Psy.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Dr. Sowald to release all information necessary to secure payment.

Signed____Date_________________________