



Dr. Carol Wright, LISW-CP, CW Counseling & Consulting, LLC  
**Contact Form**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Referring Physician/Agency: \_\_\_\_\_

**Contact Procedures:** In the event in which I must contact you, efforts will be made to ensure confidentiality. Please list below how I may contact you and how I may identify myself. For example, you might request that when I phone you at home or work, I do not identify the counseling center by name or the nature of the call, but by my name only. If this information is not provided (see below), I will adhere to the following procedure: first I will ask to speak to the client (guardian/parent) without identifying the name of the counseling center. If the person answering the call asks for more information, I will say it is a personal call. I will not identify the counseling center. If reaching an answering machine or service, I will follow the same procedure.

**Please complete the following information:**

May ☐ -or- may not ☐ call my **Home**

Home phone number: \_\_\_\_\_

May ☐ -or- may not ☐ call my **Work**

Work phone number: \_\_\_\_\_

May ☐ -or- may not ☐ call my **Cell Phone**

Cell Phone number: \_\_\_\_\_

May ☐ -or- may not ☐ **Email** appointment reminders

Email address: \_\_\_\_\_

How did you hear about Dr. Carol Wright, LISW-CP, CW Counseling & Consulting, LLC?

\_\_\_\_\_

Have you been in counseling before? \_\_\_\_\_

If yes, with whom, length, and main issues: \_\_\_\_\_

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Method of payment:

☐ **Insurance**

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

*I will need to make a copy of your card*

☐ **I do not want my insurance company billed**

☐ **Employee Assistance Company**

☐ **Self-Pay**

☐ **Other**

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Medicaid ID #