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

You have several pages to read, complete, and sign. Please feel free to ask for assistance while completing this information packet.

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: _____

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 #