Roberta E. Vose, LCSW, P.A.
Licensed Clinical Social Worker

Client Information Sheet

Date: __________________ Referred by: _______________

Full Name: ____

Gender/Identify As: ____________________ Birth Date: ____________ Age: ______

Relationship Status: ________________

Home Address: ____

Mailing Address: ____

Occupation: ____________________ Employer: _____________________________

Best Contact Number: _________________________

Preferred Method of Videoconferencing: Facetime Zoom Skype Other________

E-mail: ______________________________________

Work Phone: _________________________________

In case of an emergency, please contact: ____________________________________

Telephone: ________________________________

Primary Care Physician: ____

Telephone: ________________________________

I understand that I am financially responsible for this appointment charge (EAP Clients Excluded). I understand and am in agreement that this counseling session/appointment will NOT be filed with my insurance company. Should I wish to cancel my appointment, I understand that I need to provide 48 hours advance notice, or I will be financially responsible for the scheduled session/appointment. The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____________________Date: __________________