

River Bend Psychological Services, P.C.

Initial Contact Form

Today's Date...	
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<i>I would like help with...</i>	
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Identified Client	
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Client DOB	Client Age	Is therapy LEGALLY mandated?
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Referral Source	Who is responsible for bills?
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Client Street Address	
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City	State	Zip Code
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Client Phone#'s:	Home#	Cell#	Work#
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Client Email Address	
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Check any that apply...

It is OK to send me postal mail	<input type="checkbox"/>
It is OK to leave me phone voicemail messages	<input type="checkbox"/>
It is OK to send me email	<input type="checkbox"/>

Emergency Contact Name	Relationship to Client	Emergency Contact Phone#
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Billing Contact Name	Relationship to Client	Billing Contact Phone#
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Primary Insurance Company	Employer/Source of Insurance
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Mental Health Phone#	Provider's Phone#	Customer Service Phone#
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Subscriber/Contract Holder Name	Subscriber/Contract Holder DOB
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Member ID#	Group#
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Client's Relationship To Subscriber	Co-Pay Amt	Deductible? Y/N
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Subscriber Street Address	
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City	State	Zip Code
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