MARILYN J. WOOLEY, PH.D.

CLINICAL PSYCHOLOGIST
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Client Information

Name: _____Date: _____

Date of Birth: _____Age:_____SSN:_____

Street Address:_____City:_____State/Zip_____/_____

Telephone: Cell: _____ Home: _____ Email: _____

Marital Status: S M W Se D Name of Spouse: _____DOB: _____

Employer: _____Your Occupation: _____

Street Address: _____City: _____State/Zip: _____/_____

Insurance*

Primary Insurance Company: _____ID#_____ Group#: _____

Secondary Insurance: _____ ID# _____ Group#: _____

EAP*

Company_____ Authorization Code: _____ Start Date: _____ # Sessions_____

Contact names and phone numbers_____

_____

Workers Compensation*

Company:_____ID#:_____Pending: _____ or Confirmed: _____

Contact names and phone numbers_____

_____

***For EAP and Workers Comp, please provide letters of decision if available. For Insurance, please provide a copy of the front and back of your card.**

Emergency Contact

Name: _____Phone: _____Relationship to you: _____

Street Address: _____City_____State/Zip: _____/_____

Consent for Treatment

I, _____ give my consent for services with Marilyn J. Wooley Ph.D. and associated professional staff to include psychological testing and evaluation, psychotherapy, and involvement in the treatment process.

Client Signature: _____Date: _____

Responsible Party: _____Relationship to Client: _____

Signature: _____Date:_____