PAULA L. MARCOLIN, MS, LPC
7 Loudoun ST. SW
Suite 310
Leesburg, VA 20175

Office: 703-479-0439 Email: pl.marcolin@integrativeholistictherapy.com Fax: 571-485-8152

(Please Print)
Please check all relevant boxes

Today's Date ____/____/____

CLIENT INFORMATION

Client's Last Name	First	Middle	☐ Mr. ☐ Ms.	Marital Status (Circle One) Single / Married / Divorced / other

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ☐ **Dr.** ________ ☐ **Insurance Plan** ☐ **Website**

☐ **Family** ☐ **Friend** ☐ **Close to Home/Work** ☐ **Yellow Pages** ☐ **Other** ________

Email Address:	Alternative Email Address:

PAYMENT INFORMATION

Insured's name if different from client	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ☐ Yes ☐ No	Is this an EAP visit? ☐ Yes ☐ No	Total Annual EAPs allowed? ________

What is exact name of insurance?	

What is the authorization number?	What is coinsurance %? ________	☐ **Self Pay** ☐ **I choose to not have an electronic record kept if I self pay**

Is there a Deductible?	**# of sessions allowed per calendar year?**	SS # / /	Group #	Policy #	**Co-Payment** $

Client's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ________

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Client / Parent Signature **Date**