Sharyn Schreiber Pinney, LCSW

Client Profile Form

PLEASE PRINT

Personal Information

Name		Date of Birth			Social Security Number		
Last	*First*	*MM*	*DD*	*YYYY*	*###*	*##*	*####*

Address				
Street	*Apt #*	*City*	*State*	*Zip Code*

Telephone & Email *(check ✓any box where you DO NOT wish to be contacted)*

☐	☐	☐	☐
Home	*Office*	*Cell*	*Email*

Household Members

Name	Relationship to you	Age

Employment

Employer	Occupation

Employer Address				
Street	*Suite #*	*City*	*State*	*Zip Code*

Spouse/Partner's Employer	Spouse/Partner's Occupation

Spouse/Partner's Employer Address				
Street	*Suite #*	*City*	*State*	*Zip Code*

Emergency Contacts

Name	Relationship to you	Telephone	
		Home / Office	*Cell*

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Client Profile Form, continued

Confidentiality of Records Policy

All records kept by this office or received by this office regarding you and your care is confidential. Records are secured in a locked file cabinet. If there is a need for me to communicate with another health care professional regarding your care, it is necessary to have your written permission to do so. A release of information is also required should another health care professional wish to communicate information to me regarding your care.

Exceptions to this policy are as follows:

- Life-threatening emergency
- Threat of harm to self or others
- Reason to suspect child abuse or elder abuse
- Court-ordered subpoena or records/request for summary report

Regarding Insurance:

Sharyn Schreiber Pinney, LCSW ***does not*** accept assignment for any third-party payments. All fees are due at the time of service. Upon request, you will be furnished with a statement of services should you wish to file a claim with your insurer for reimbursement to you.

Please refer to the attached ***Consent for Release of Confidential Information*** form.

Please feel free to ask any questions concerning these policies.

I have read and understand these policies.

_____ _____

Signature *Date*