Long Island Cognitive Wellness Counseling Services, LCSW, P.C.
Lianne E. Conroy, LCSW-R
269 West Main Street, Bay Shore, NY 11706
631-913-8201
lconroylcsw@gmail.com
www.licognitivewellness.com

DATE: _____

CLIENT INFORMATION

This section is for the client's information only. Parent/Guardian information can be recorded in the next section.

NAME:	**D.O.B. :**
SOCIAL #:	**GENDER:** ☐ Male ☐ Female

EMPLOYMENT STATUS: ☐ Full-Time ☐ Part-Time ☐ Full-Time Student ☐ Unemployed

RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ In committed relationship

ADDRESS:

HOME PHONE:	**MOBILE PHONE:**
WORK PHONE:	**E-MAIL:**

EMERGENCY OR BILLING CONTACT #1

NAME: ☐ Emergency Contact ☐ Handles Billing

RELATIONSHIP: ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other:

ADDRESS:

HOME PHONE:	**MOBILE PHONE:**
WORK PHONE:	**E-MAIL:**

EMERGENCY OR BILLING CONTACT #2 (OPTIONAL)

NAME: ☐ Emergency Contact ☐ Handles Billing

RELATIONSHIP: ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other:

ADDRESS:

HOME PHONE:	**MOBILE PHONE:**
WORK PHONE:	**E-MAIL:**

Sign to indicate that we have permission to communicate with the persons listed above in emergency situations and/or with billing questions, as per your indication: _____

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INSURANCE INFORMATION

INSURANCE COMPANY:	**ID #:**
PLAN NAME:	**GROUP #:**
COMPANY PHONE #:	**EMPLOYER:**
CLIENT'S RELATIONSHIP TO POLICYHOLDER: ☐ Self ☐ Spouse of Insured ☐ Child of Insured	

POLICYHOLDER INFORMATION

This section only needs to be completed if the client is not the policy holder.

FULL NAME:	**D.O.B. :**
SOCIAL #:	**GENDER:** ☐ Male ☐ Female
ADDRESS:	
BEST PHONE NUMBER:	

COVERAGE DETAILS (OFFICE USE ONLY)

Active Date:

Copay:

Deductible:

Authorization Number:

Coinsurance:

Allowable Visits:

Additional Notes:

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COMMUNICATION CONSENT

Out of respect for your privacy, the staff of the Long Island Center for Cognitive Wellness will only contact you via the methods of communication that you specifically consent to. Please complete this form by filling in any phone numbers or e-mail addresses that we have permission to use. Check the boxes to indicate your preferences.

NOTE: Whenever returning telephone calls and the answering machine picks up, we do not leave any messages that would include private/personal information about your health or treatment. Additionally, information will not be left with any unauthorized persons.

ADULT CLIENTS (ENTER PARENT/GUARDIAN INFORMATION HERE IF CLIENT IS A MINOR)

HOME PHONE: ☐ OK to call ☐ OK to leave message

WORK PHONE: ☐ OK to call ☐ OK to leave message

MOBILE PHONE: ☐ OK to call ☐ OK to leave message ☐ OK to text

E-MAIL: ☐ OK to send e-mail

SIGNATURE:

The clinicians at the Long Island Center for Cognitive Wellness encourage clients to reach out when they need assistance implementing the skills learned in treatment into their daily lives. Our office requires specific permission from parents/guardians before we communicate directly with minors. If you would like to grant us permission to communicate with your child or teen via phone or e-mail, please complete the following section.

CONTACT INFORATION FOR INDIVIDUALS UNDER 18 (OPTIONAL)

HOME PHONE: ☐ OK to call ☐ OK to leave message

MOBILE PHONE: ☐ OK to call ☐ OK to leave message ☐ OK to text

E-MAIL: ☐ OK to send e-mail

PARENT/GUARDIAN SIGNATURE:

The Long Island Center for Cognitive Wellness plans to begin sending electronic appointment reminders through a HIPPA compliant scheduling program sometime in the near future. If you would like to sign up for electronic appointment reminders, please complete the section below. Please note that this service is strictly a courtesy; clients are responsible for attending all scheduled appointments regardless of if they receive an appointment reminder.

ELECTRONIC APPOINTMENT REMINDER ENROLLMENT

E-MAIL: **SIGNATURE:**