

D'Arcy Vanderpool, MA. PCC

D'Arcy Vanderpool and Associates

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CLIENT INFORMATION SHEET

Therapist: _____

CLIENT INFORMATION

First Name _____	Last Name _____
Address _____	City _____ Zip Code _____
Home Phone _____	Work Phone _____ Cell Phone _____
Please indicate where you prefer to receive calls. Home ____ Work ____ Other ____	
Email _____ (print carefully)	
Employer _____	Address _____
SS# _____	Birthdate _____ Age _____ Occupation _____
Marital Status : Single ____ Married ____ (years) Separated ____ Divorced ____ Widowed ____	

SPOUSE INFORMATION

Name _____	Birthdate _____	SS # _____
Employer _____	Address _____	
Work Phone _____	Cell _____	Email _____ Occupation _____
Other Household Members _____		

INSURANCE INFORMATION (Please give insurance card to Therapist to photocopy)

Primary Insurance Co. _____			
Name of Insured _____	Relationship to Client _____		
ID# _____	Group# _____	Policy # _____	Phone# _____
Secondary Insurance Co. _____			
Name of Insured _____	Relationship to Client _____		
ID# _____	Group# _____	Policy # _____	Phone# _____

RESPONSIBLE PARTY

Name _____	Phone # _____
Address (if different from above) _____	

Referred By _____ Family Physician(s) _____

Reason for my visit _____

In case of emergency, please notify: _____

Relationship _____ Phone Number _____

I authorize all benefits to be paid directly to D'Arcy Vanderpool, PhDC, MA. I understand that I am fully responsible for all expenses associated with my psychotherapy, including appointments not cancelled 48 hours in advance.

SIGNATURE: _____ DATE: _____