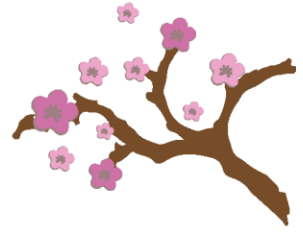




KATRINA L. LOKKEN, PSY.D.

Licensed Psychologist
katrinalokkenpsyd@gmail.com
www.drlokken.com



Client Information Form

Date _____

Client's Name: Last _____ First _____ M.I. _____

Client's Date of Birth: _____ Sex: M _____ F _____

Client's SSN: _____ - _____ - _____ *If client is a minor, name & relationship of responsible party:

Guardian's Name: Last _____ First _____ M.I. _____

Relationship to Client: _____ Single _____ Married _____ Divorced _____

Street Address (No P.O. Boxes) _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ E-mail address: _____

May we call to confirm appointments? Yes _____ No _____ Emergency Phone () _____

Primary Insurance Carrier _____ Policy / Group # _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's ID/SSN: _____ - _____ - _____ Insured's Employer: _____

Who referred you to our office? _____

I request that payment of authorized third party benefits be made on my behalf to Dr. Katrina L. Lokken, Psy.D., P.C., for any services furnished to me by her or her assistants. I understand my signature also authorizes release of any information contained in my records to any relevant insurer, or to its assignees, necessary to pay a particular claim. By my signature, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason.

Signature of Client or Responsible Party

Date