RAYE LYNNE DIPPEL, PH.D.
Clinical Psychologist

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CLIENT INFORMATION

Today's Date: _____
Name(s): _____ Sex: M / F DOB(s): _____ Age: _____
Street, City & Zip: _____CO _____
Home Phone: _____Cell Phone: _____ OK to call? _____
Work Phone: _____ OK to call? _____
Email:_____
Please indicate how BEST to contact you: _____
Employer / School: _____Occupation:_____
Education: _____ School (if applicable): _____
Name of Spouse:_____ Phone: _____
Children and Ages:_____
Referred by: _____
Primary Care Physician: _____ Phone/Email: _____
Psychiatrist: _____ Phone/Email:_____

If Client is a minor

Father's (guardian) name: _____ DOB: _____Phone:_____
Address: _____ Employer: _____
Mother's (guardian) name: _____ DOB: _____
Phone:_____
Address: _____ Employer: _____

Primary Insurance Plan:

Name of Company: _____ Phone: _____
Address for Claims: _____ Subscriber/Member ID: _____
Group no. or Name: _____ Policy No.: _____
Name of Subscriber: _____ DOB of Subscriber: _____
Social Security No. of Subscriber: _____ Authorization No.: _____
Co-pay Amount: _____
**Please bring along your insurance card with you on your first visit*

Secondary Insurance Plan (if applicable):

Name of Company: _____ Phone: _____
Address for Claims: _____ Subscriber/Member ID: _____
Group no. or Name: _____ Policy No.: _____
Name of Subscriber: _____ DOB of Subscriber: _____
Social Security No. of Subscriber: _____ Authorization No.: _____

Authorization:
The above information is warranted to be true. I agree to be responsible for the charges incurred. If insurance is available, I authorize release of information for the purposes of filing claims, and also authorize payment of benefits directly to Dr. Raye Lynne Dippel.

_____ Date:_____
Signature of Responsible Party