Paula Hofmann, MA, LPCC
Licensed Professional Clinical Counselor
NEW CLIENT INFORMATION & WELCOME

Thank you for selecting my practice. Please complete the following information for your records.

Name: ____________________________________ Date of birth: _____________________ Age: ____
Address: __________________________________ City________________________ ZIP___________
Okay to send mail to home______ NO MAIL____
Home phone: _______________________________ Okay to leave msg ____NO MSG_____
Cell phone: _________________________________ Okay to leave msg ____NO MSG_____
Work phone: _________________________________ Okay to leave msg____ NO MSG____
Email Address: ______________________________
(I understand Email and text communications are not secure, but would ___ would not ____like to communicate via email or text for the purpose of scheduling or canceling appointments only).

EMERGENCY CONTACT: ____
Relationship:_______________________ Cell Phone: _____________ Home: ___________________
Work: _____________________________
By signing below, I give permission for you to contact the above individual for
_____ emergency only _____disclosure of medical information and emergency.
Signature______________________________________ Date: ___________________________________
ALL INSURANCE INFORMATION MUST BE COMPLETED:
Insurance Coverage: ___________________Name of Insured:________________________________
Patient: Relationship:__________________ Insured's Address: _________________________________
DOB of Insured:___________________ Employer: ____
Policy number: ____________________________ Group Number:__________________________
Type of Insurance(PPO, HMO, etc)____________ Insured's Phone #:_______________________

Referred by:
____
Primary Care Physician: _________________ Psychiatrist: ___________________________________ C

Current meds:____In
Please describe why have you decided to see a counselor or what would you like help with?
____
____
____ _

Welcome to my practice. I will do all I can to make sure that you feel safe & comfortable enough to trust in our therapeutic alliance. Please remember that while growth is sometimes difficult, change is necessary is to become the persons we want to be. I will most likely learn from you, just as you will learn from me. Thank you for your willingness to make the first step on your journey with me.

Limits of confidentiality: By law, there are exceptions to confidentiality for the following purposes:
For Treatment: We may use medical information about you to provide you with services.
For Payment:We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company, or a third party.
For Health Care Operations: We may use and disclose medical information about you for health care operations to ensure that you receive quality care.
Other possible disclosures: As required by laws of the state of Ohio or the guidelines of the Mental Health Profession.
Please see privacy statement and informed consent for more detailed information.