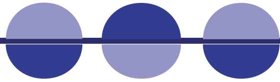

Holly Bielstein Savoy, Ph.D.
Licensed Psychologist

5970 Fairview Road, Suite 412, Charlotte, NC, 28210
Phone: 704.362.4041 Fax: 704.362.1170

CLIENT INFORMATION FORM

Legal Name: ________________________________ Preferred Name: ______________________
Date of Birth: _________________ Pronouns: ( )He/Him ( )She/Her ( )They/Them
Home Address: __________________________ _______________ _____ ______
Address City State Zip code

Please list all phone numbers where we may contact you ***and have permission to leave a message***, if necessary. Please indicate order of preference for which numbers we call and do NOT write in a phone number you do not want us to call.
1. ____________________ ( ) Home ( ) Work ( ) Cell
2. ____________________ ( ) Home ( ) Work ( ) Cell
3. ____________________ ( ) Home ( ) Work ( ) Cell

If you would like **APPOINTMENT REMINDERS**, please initial beside your preferred method of contact indicating permission for reminders to be sent via the scheduling software:
____ text ____ email ____ voicemail. If text, which number listed above ___________________

Email: ________________________________ (providing indicates permission to use)

Employer/School: __________________________ Occupation/Grade Level: _______________

Gender: ______________ Ethnicity: ________________

Relationship Status (circle): Single Married Life Partner Separated Divorced Dating Widowed

Emergency Contact (In case of emergency, who should we contact?)

______________________________ ___________________ _______________________
Name Contact Number Relationship to Client

Who referred you? ______________________ May we thank the person for the referral? Yes/No

If not referred, how did you get our name? ______________________________

List Family:

Relation (Parents, Stepparents, Siblings, Children, Spouse/Partner, Other)	Age	Highest Level of Education Completed	Occupation
_____________________	___	________________	___________
_____________________	___	________________	___________
_____________________	___	________________	___________
_____________________	___	________________	___________
_____________________	___	________________	___________

PRIMARY INSURANCE:

(Please provide your insurance card so we may keep a copy on file)

Subscriber's Name:___________________________________ Relationship to Patient:______________

Subscriber's Birth Date: ___/___/____ Employer:_________________

Authorization to Pay Benefits & Release Information: I authorize payment of benefits to Holly Savoy, Ph.D., for services provided and I authorize Holly Savoy, Ph.D. to release to my insurance company any medical information necessary to process this claim and/or obtain authorization for treatment.

Signed:____ Date:__________________

PSYCHIATRIC/PSYCHOLOGICAL TREATMENT

Name of treating Psychiatrist, if any:____

Name of previous psychologist(s) or therapist(s), if any: _______________________________________

Describe any type of past counseling, psychiatric, or mental health treatment you have received:

____

____

____

MEDICAL HISTORY

Name of Physician/PCP:_________________________________ Phone:______________________

PCP Group or Practice Name:____

Name of any other physicians currently treating you:____

Date of last physical: ________________

Current health issues? ____

Current medical symptoms:____

Current Medications:

Name Dosage Start Date Side Effects

____

____

____

____

Have you taken medication in the past? Yes / No

If yes, please list type and for how long? ____

____

____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN, SURGEON, PSYCHIATRIST, OR ANOTHER TREATMENT PROVIDER:

It is often helpful to coordinate treatment between a Psychologist and other treatment providers. Also, many insurance companies encourage coordination of treatment between the Psychologist and other healthcare providers. Please indicate below if you are willing to allow such communication.

I hereby ***authorize*** Holly Savoy, Ph.D. to release confidential clinical information, including intake summary, treatment goals, treatment recommendations, and pertinent progress notes to the provider(s) indicated below in order to aid in treatment planning and coordination. This release is valid for ***two years***, unless otherwise stated. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further understand that I may revoke this consent at any time, except to the extent that action based on this consent has been taken.

Provider Name: ___________________________________

Practice Name: ____________________________________

Phone #: ___________________________________

Address: ___________________________________

____

____

Provider Name: ___________________________________

Practice Name: ____________________________________

Phone #: ___________________________________

Address: ___________________________________

____

____

Provider Name: ___________________________________

Practice Name: ____________________________________

Phone #: ___________________________________

Address: ___________________________________

____

____

Printed Legal Name: ___________________________ **Preferred Name:** __________________________

Signed:____________________________________ **Date:**______________________ Rev. 1-20