STARFISH EXPERIENCE INC.
SHEILA F. KAMINSKI, LCSW
Licensed Clinical Social Worker
Psychotherapy and Counseling
99 Kinderkamack Rd Suite 308
Westwood, New Jersey 07675

CLIENT INFORMATION SHEET

All information MUST MATCH Insurance carrier information

CLIENT NAME_________________________________ (Male / Female) CONTACT#____________________

CLIENT ADDRESS____
(Street Address) (Town) (Zip Code)

DATE OF BIRTH_________________ RELATIONSHIP STATUS: (Single / Married / Widowed / Divorced)

CLIENT's INSURANCE CATAGORY: *CHOOSE ONLY ONE* (Primary / Spouse / Child / Other)

IF OTHER THAN "PRIMARY" IS SELECTED - Please Provide the following

PRIMARY INSURED's FULL NAME________________________________ DATE OF BIRTH_______________

ADDRESS____
(Street Address) (Town) (Zip Code)

WITH WHOM ARE YOU LIVING? LIST NAMES, AGES AND RELATIONSHIP:_____________________________
____
____
____

DO YOU DRINK ALCHOHOL? (Yes / No) HOW MUCH PER WEEK?_________________________________

DO YOU USE RECREATIONAL DRUGS? (Yes / No)

CURRENT MEDICATIONS____
____
____

THERAPIST NAME:______________________ REFERRED BY:____

I authorize the release of any information necessary to process claims for services rendered by Sheila F. Kaminski L.C.S.W., and or, Starfish Experience Inc. I also authorize the payment of benefits directly to Sheila F. Kaminski L.C.S.W., and or, Starfish Experience Inc. for any and all services rendered by Sheila F. Kaminski L.C.S.W., and or, Starfish Experience Inc.

CLIENT SIGNATURE:____ DATE:_________________________