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ACSW, MSW

Patient Information Form

Date_____ Soc. Sec. # _____ Birth Date_____

Name:_____
Last Name First Name Initial

Address_____ City _____State_____ Zip _____

Home Phone _____Cell Phone _____ E-mail_____

May I leave messages on: Phone ☐ Yes ☐ No Email ☐ Yes ☐ No

May I send relative healthcare or practice information via e-mail? ☐ Yes ☐ No

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer_____ Occupation _____

Business Address _____ Business Phone_____

Who should I thank for referring you? _____

In case of emergency, who should I contact?_____ Phone:_____

Primary Insurance

Person Responsible for Account (Same ☐) _____
Last Name First Name Initial

Relationship to Patient _____Birth Date_____ Soc. Sec. # _____

Address_____ City _____State_____ Zip _____

Home Phone _____Cell Phone _____ Email_____

Responsible Party Employed By_____ Occupation _____

Business Address _____ Business Phone_____

Insurance Company_____ Subscriber I.D. # _____ Group #_____

Insurance Company Address_____ City _____State_____ Zip _____

Additional Insured (If Applicable)

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____Birth Date_____ Soc. Sec. # _____

Address_____ City _____State_____ Zip _____

Email _____ Home Phone _____Cell Phone_____

Responsible Party Employed By_____ Occupation _____

Business Address _____ Business Phone_____

Insurance Company_____ Subscriber I.D. # _____ Group # _____

Insurance Company Address_____ City _____State_____ Zip _____

Assignment & Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and for all services rendered on my behalf or my dependant.

I authorize the above Psychotherapist to release any information required to secure the payment of my benefits in accordance with State and Federal regulations (HIPAA) . I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date ___/___/___

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