

PLEASE PRINT

CONFIDENTIAL CLIENT INFORMATION

Date: _____

Name: _____
First Middle Last

Address: _____
Number Street City State Zip

Mailing Address (If Different): _____
Number Street City State Zip

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

OK to Call? Yes No Yes No Yes No
OK to Leave Message? Yes No Yes No Yes No

Social Security #: _____ - _____ - _____ Date of Birth: _____ Email: _____

Sex: Male Female Marital Status: Single Married Divorced Separated Other _____

Employer: _____ Full Time Part Time

Student: Full Time Part Time Referred by: _____ OK to Acknowledge Referral? Yes No

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Ins. Phone #: _____

Address: _____

Policy Holder: Name: _____ Date of Birth: _____

Address: _____ Sex: Male Female

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Email: _____

Social Security Number: _____ - _____ - _____ Policy/I.D. Number: _____

Group Number: _____

Relationship of patient to insured: Self Spouse Child Other _____

Secondary Insurance Carrier: _____ Ins. Phone #: _____

Address: _____

Policy Holder: Name: _____ Date of Birth: _____

Address: _____ Sex: Male Female

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Email: _____

Social Security Number: _____ - _____ - _____ Policy/I.D. Number: _____

Group Number: _____

Relationship of patient to insured: Self Spouse Child Other _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Payment (If other than patient)

Name: _____ check if: Custodial Parent Legal Guardian

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Relationship to Patient: _____ Email: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other informaton necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: _____ DATE: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to Michael Vernon, LCSW for all services provided.

SIGNED: _____ DATE: _____

FOR OFFICE USE ONLY: Dx: _____ Copay: _____ Fee: (for 90801) _____ (for 90806) _____ New Patient: Yes No

Insurance Billing: Ins. Co. #1 Ins. Co. #2 None

Patient Billing: Copayment bill only Total balance due statement with diagnosis for all activity Do not bill this patient

Managed Care: Yes No # of Sessions Auth'd _____ Start _____ End _____ Auth. # _____

Therapist: #101076 - Vernon Special Instructions: _____