Cheryl Jones-Dix, LCSW
Licensed Clinical Social Worker # LCS10781
4401 Atlantic Ave, Suite 430
Long Beach, California 90807
(562) 372-6026

PATIENT INFORMATION

Party 1: Name:_____

Date of Birth:_____ Social Security No.:_____

Address:_____
street city zip

Home phone:_____ Cell phone:_____

Workplace/Occupation: _____/_____

Work phone:_____ Email addr: _____
(Put * next to preferred # for me to leave you messages)

Party 2: Name:_____

Date of Birth:_____ Social Security No.:_____

Address:_____
street city zip

Home phone:_____ Cell phone:_____

Workplace/Occupation: _____/_____

Work phone:_____ Email addr: _____
(Put * next to preferred # for me to leave you messages)

Children:
Name: _____ Date of Birth: _____ M F

Name: _____ Date of Birth: _____ M F

Name: _____ Date of Birth: _____ M F

Name: _____ Date of Birth: _____ M F

Referred by:_____

Reason for seeking counseling:_____

Insurance/Billing

Please indicate which party will be responsible for billing. This name will appear on the monthly billing statement.

Patient Name: _____Birthdate: _____

Plan Name:_____ Member ID#:_____

IF YOUR PROVIDER IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION:

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Cheryl Jones-Dix, LCSW the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for me or my dependents. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

Signed: _____
Insured

Signed: _____
Patient /Guardian

Date: _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Cheryl Jones-Dix, LCSW. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

GUARANTOR SIGNATURE (Patient signature, if patient is Guarantor):

_____

Date: _____