CANO COUNSELING

www.canocounseling.com

Gladys J. Cano, LICSW
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Date _____ PCP _____

Patient Information

LAST NAME FIRST MIDDLE BIRTH DATE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED **SEX:** ☐ M ☐ F

ADDRESS CITY STATE ZIP CODE

PHONE NUMBER EMAIL

Person Resposible For Bill

☐ SELF (*Same as patient)* ☐ OTHER—*(If other print name of responsible party)* BIRTH DATE

ADDRESS (*If different from patient)* CITY STATE ZIP CODE

PHONE NUMBER EMAIL

Insurance Information

PRIMARY INSURANCE CLAIMS MAILING ADDRESS INSURANCE PHONE

SUBSCRIBER NAME — Patient Relationship to Subscriber ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER # GROUP # OR ID # SUBSCRIBER BIRTH DATE

Insurance Authorization and Assignment

Before Signing Please Check Each Acknowledgment Line

☐ I hereby authorize Gladys Cano, LICSW to furnish information to my carrier concerning my health related treatment. I hereby assign Gladys Cano, LICSW all payments for medical services rendered to myself or my dependents.

☐ I understand that I am responsible for any amount not paid by my insurance within 90 days.

☐ I understand that payment for services is required upon completion of my visit by cash or check.

PATIENT'S SIGNATURE DATE