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GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please submit form with front and back of insurance card (if you have one). May be emailed or texted. Thanks!

Patient Name:_____ Today's Date:_____

Age:_____ Date of Birth (DOB):_____

Address:_____

Parent, Spouse, or Family Member Name (if applicable): _____

Home phone:_____May I leave a message? Yes No

Cell phone:_____May I leave a message? Yes No

Emergency Contact (Name and #): _____

Email: _____May I email you? Yes No

INSURANCE INFORMATION

Insurance Company:_____ Name of Insured:_____

Insured's Date of Birth: _____ Insured's SSN #:_____

Insured's Employer:_____ Policy Name: _____

Insured's Member ID #:_____ Insured's Group #:_____

Insured's Relationship to the Client:_____

Authorization # (if needed):_____Customer Service Phone # : _____

Address for Submitting Claims: _____

The above information is accurate to the best of my knowledge. I understand I am financially responsible for any copayments or fees if my insurance company is unable or refuse to provide payment. I authorize Mary Beth Del Balzo, LCSW, CHt to release any information required to process claims for services rendered.

_____ _____
Responsible Party Name Phone Number

X_____ _____
Responsible Party Signature Date