**Mary Beth Del Balzo, LCSW, CHt**

**18 Sycamore Avenue**

**2nd Floor**

**Ho Ho Kus, NJ 07423**

**NJ License #44SC05355900**

**GENERAL INFORMATION**

*Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session with your insurance card (if you have one)***.**

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.

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Responsible Party Name Phone Number

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature Date