Swanson, Conti & Associates

A Psychological Corporation
818.986.9666
www.SwansonContiAndAssociates.com
16311 Ventura Boulevard, Suite 925
Encino, California, 91436

Responsible Billing Party

Name: _____ Date of Birth: _____

Mailing Address: _____ Email Address: _____

_____ Home Phone: _____

Cell Phone: _____

Swanson, Conti and Associates does not participate with any insurance provider. Payment is due at the time of service. If you would like to receive a superbill to send to your insurance provider for reimbursement, please complete the Superbill Request Form found at www.SwansonContiAndAssociates.com.

Acknowledgements

Initial: _____ *By initialing here, I understand that I will be responsible for paying for all services according to the fee schedule provided.*

Initial: _____ *By initialing here, I acknowledge that I have been provided a fee schedule and understand all applicable charges.*

Client Information

Client Name: _____ □ Same as above

Age: _____ Date of Birth: _____ Sex: □ Male □ Female □ _____

Other people in the home including name(s) / age(s):

_____

Reason(s) for seeking treatment:

_____

_____

Previous Therapist: _____ Dates of Treatment: _____

Client's Physician: _____ Client's Psychiatrist: _____

Current Medical Conditions: _____

Current Medications: _____