



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, once can be provided to you.

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: _____