Catherine A. Casey, LPC, LMFT
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PERSONAL INFORMATION

Name: ______________________________ DOB: ___/___/___ Age: _____ M ___ F___

SSN: ___________________ Marital Status: ___________________ Yrs Married ______

Street Address: ____

City: _____________________ State: ______________ Zip: ________________________

Home Phone: ___________________

May I contact you at home? Yes No Leave a message on your home answering machine? Yes No

May I send mail to your home address? Yes No

Email Address (enter only if I may contact you by email): _______________________________

Emergency Contact:

Name: ________________________________ Phone: _____________________
Relationship to you: ____________________

CLIENT EMPLOYER: ____
WORK ADDRESS: ____
WORK TELEPHONE: ____________________________________

May I call you at work? Yes No May I leave a message for you at work? Yes No

If spouse/partner will be involved in therapy, please provide the following information on spouse/partner:

SPOUSE/PARTNER: _________________________ DOB: ___/___/___
SPOUSE/PARTNER SSN: __________________
SPOUSE/PARTNER EMPLOYER: ____
SPOUSE/PARTNER WORK TELEPHONE: __________________________

May I call you at work? Yes No May I leave a message for you at work? Yes No

OTHER HOUSEHOLD MEMBERS

Name: ____________________ Age ______ Relationship _________________________

Name: ____________________ Age ______ Relationship __________________________

Name: ____________________ Age ______ Relationship __________________________

INSURANCE INFORMATION

Complete this section if you will be using any Health Insurance plan as part of your payment for services.

INSURANCE COMPANY NAME: _______________________________
I.D. #:__________________________
Group or Plan #:_________________
Insurance Company Benefits Phone #: _______________________
Insurance Company Address (if on your card): ____

Policy Holder: __________________________ DOB: ___/__/___
Relationship to Patient: _____________________________

SECONDARY INSURANCE

If you have secondary insurance, complete this section.

INSURANCE COMPANY NAME: ___________________________
I.D. #:____________________
Group or Plan #:_________________
Insurance Company Benefits Phone #: _______________________
Insurance Company Address (if on your card): ____

Policy Holder: __________________________ DOB: ___/__/___
Relationship to Patient: _____________________________

Signature on File and Authorization of Benefits Statement:

I am the client or a person responsible for the client. I authorize the use of this form on all my insurance submissions for services from this practitioner, Catherine A. Casey, LPC, LMFT. I authorize the release of medical or other information to my insurance company. I understand that I am responsible for my bill. I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies. I authorize payment of medical benefits directly to my therapist. I permit a copy of this authorization to be used in place of the original. I have read and understand this agreement.

DATE: ______________________ SIGNATURE: ______________________________