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: _____ Mobile 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 May I leave a message on your cellphone? 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

<u>OTHER HOUSEHOLD MEMBERS</u>

Personal Information

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: _____