PATIENT INFORMATION SHEET

Linda Lafferty, LMFT

Shaded areas MUST BE FILLED IN

☐ VICTIM WITNESS ☐ INSURANCE ☐ PRIVATE _____ DX DATE _____

LAST NAME _____ **FIRST** _____ **M.I.** _____

ADDRESS _____ **APT #** _____

CITY _____ **STATE** _____ **ZIP** _____ **PHONE** _____

PATIENT SS# _____ **DATE OF BIRTH** _____ **AGE** _____ **WORK** _____

EMAIL _____

FAMILY INFORMATION (MINORS ONLY)

FATHER _____ PHONE _____ WORK _____

DATE OF BIRTH _____ ADDRESS _____

SS# _____

MOTHER _____ PHONE _____ WORK _____

DATE OF BIRTH _____ ADDRESS _____

SS# _____

GUARDIAN _____ PHONE _____ WORK _____

DATE OF BIRTH _____ ADDRESS _____

EMERGENCY CONTACT NUMBERS

NAME _____

RELATIONSHIP _____ PHONE _____

INSURANCE INFORMATION

Please supply a photo copy of your insurance card both front and back

INSURED PERSON _____

SSN _____

DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

ADDRESS _____

_____

PHONE # _____ FAX # _____

PLAN # _____ MEMBER # _____

PRECERTIFICATION REQUIRED? ( ) YES ( ) NO

CO-PAY REQUIRED? ( )YES ( ) NO

CO-PAY AMT _____

I hereby give my consent for treatment, and authorize any necessary communication between my therapist and/or her agent, and my insurance company. I agree that I am aware I am responsible for any session charges my insurance company won't pay for. I also agree to this offices HIPPA compliance to make a professional effort to maintain the privacy of all clients, in line with industry standards.

_____

PATIENT SIGNATURE (Parent or Guardian, if minor)