Cynthia L. Sarris, LCSW, LLC | Dana M. Pelliccia, LPC | Andrea C. Basel, LCSW | Emily Samander, LMSW

Date ____________ Home Phone ____________________ Cell ________________________

Patient ____
Last Name First Name

Responsible Party (if minor) ____

Street Address ____________________________________ Email ____________________

City __________________________ State ____________ Zip ______________________

Sex ☐ M ☐ F Age ______ Birth-date ______ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Employer/School ____

Occupation ______________________________________ Buisness Phone ______________

Spouse (or responsible party) Name __________________________ Birth-date ______________

Business Name and Address ____

Occupation ______________________________________ Business Phone ______________

Who is responsible for this account? _____________________ Relationship to Patient ______________

Social Security # _________________________________ Spouse's Social Security # ______________

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer ____________________________ Policy Holder ______________

Subscriber # ________________________ Group # ______________ DOB ______________

Name of Secondary Insurer (if any) ____________________ Policy Holder ______________

Subscriber # ________________________ Group # ______________ DOB ______________

☐ Medicare ☐ Medicaid Claim ID# ______________________________________

If Welfare, your number ____

In case of emergency, who should be notified? ________________________ Phone ______________

How did you learn of our practice? ____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with ______________________________________
Name of Insurance Company(ies)

and assign directly to Dr. __________________________ all insurance benefits, I any, otherwise payable services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end current treatment plan is completed or one year from the date signed below.

Medlcare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, medigap benefits, be made either to me or on my behalf to ______________________ for any services furnished to me by that provider.
Name of Doctor