Contact Information **Todays Date:**

Name:			
Phone:		Message ok?	
*EMAIL:			
Street Address:			
City, State, Zip			
Age:		Birthdate: Mo/Day/ Year	____ /____ /_____
Occupation:			
Employer Name			
Employer Address			

Emergency contact:	
Phone:	
Relationship:	
May I leave a message with this person in an emergency?	yes / no

HEALTH INSURANCE INFORMATION: If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

PATIENT'S SEX M_____ F_____

PATIENTS' RELATIONSHIP TO INSURED:
SELF___ SPOUSE____ CHILD_____ OTHER____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

NAME OF INSURED _____

STREET ADDRESS _____

_____

TELEPHONE _____ PATIENT'S DATE OF BIRTH _____

INSURED'S PLACE OF EMPLOYMENT: _____

INSURANCE PLAN NAME OR PROGRAM NAME._____

INSURED'S INSURANCE ID NUMBER_____

POLICY GROUP NUMBER _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Vicki Sween, MA, LMHC, ad to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

_____ Date _____

Signature of Insured