Schwartz
Therapy + Wellness, P.C.
small steps every day

Updated 10/18

PRINT

SUBMIT

Client Information Sheet

Schwartz Therapy + Wellness, P.C.
Mallory Schwartz, MA, LPC, NCC
Please Print Clearly

Client Full Name: _____

Date of Birth: _____ Gender: M/ F Phone #: _____

Relationship of Insured: SELF _____ SPOUSE _____ DEPENDENT _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Emergency Contact/ Relationship: _____

Phone: _____ E-mail: _____

INSURANCE CARRIER INFORMATION

Name of Primary Insurance Carrier: _____

Insured Name (subscriber/employee): _____

Insured's ID# (front of card): _____Group #:_____

Insured's Address: _____

City, State, Zip: _____

Card Holder's Date of Birth: _____ Phone #: _____

SECONDARY CARRIER INFORMATION

Name of Secondary Insurance Carrier: _____

Insured Name (subscriber/employee): _____

Insured's ID# (front of card): _____Group #: _____

Insured's Address: _____

City, State, Zip: _____

Card Holder's Date of Birth: _____ Phone #: _____

PLEASE INCLUDE A COPY OF THE INSURANCE CARD (S) FRONT + BACK

I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government or private benefits to my provider who accepts assignment of benefits on this claim(s).

X _____ _____

Signature of Financially Responsible Party Date