# PEYMAN RAOOFI PSY.D.
# CLINICAL PSYCHOLOGIST | PSY31559

Date: _____/____/ 20______

**PATIENT'S INFORMATION:**

Name: ____________________________________________________

Address: ___________________________________________________________________________

City: __________________________________ State: _________ Zip code: ________________________

Phone: Home: (_____)_______-________Mobile: (_____)______-_______Work: (_____)______-______

Sex: Male [ ] Female [ ] Date of Birth: ______/______/______ Age: ______

Marital Status: Single [ ] Married [ ] Divorced [ ] Widow [ ]

Referred by: ___________________________________________

**RESPONSIBLE PARTY IF NOT THE PATIENT (statements will be sent to):**

Name: __________________________________ Relationship to patient: ___________________________

Address: ___________________________________________________________________________

City: _________________________________ State: _________ Zip code: _________________________

Phone: Home: (_____)_______-________Mobile: (_____)______-_______Work: (_____)______-______

**EMERGENCY CONTACT:**

Name: __________________________________ Relationship to patient: ___________________________

Phone: Home: (_____)_______-________Mobile: (_____)______-_______Work: (_____)______-______

**PRIMARY INSURANCE INFORMATION:**

Insurance Company: ____________________________ Phone #: (______)________-_________

Subscriber's Name: _____________________________ SS#: _________-__________-_________

Employer: ____________________________________ Group #: ___________________________

Subscriber's ID: _______________________________ Date of Birth: _______/________/_______

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.
AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: ___________________________________________ DATE: ______/______/ 20______
(patient, or parent if patient is a minor)