

CLIENT INFORMATION

Client's name: _____ Male/Female: _____

Birth date: ____/____/____

Address: _____ City, State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____ Email: _____
 Can we leave a message? Yes ___ No ___ Yes ___ No ___ Yes ___ No ___

Client's Employer: _____ Position: _____

Employer address: _____ City, State: _____ Zip: _____ Employer Phone: _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___

Spouse name: _____ Phone: _____ Date of Birth: _____

In case of emergency contact: _____ Relation _____ Phone: _____

MEDICAL INSURANCE INFORMATION

Subscriber Name: _____ ID: _____

Primary Insurance Co. _____ Policy No. _____ Group No. _____

Secondary Insurance Co. _____ Policy No. _____ Group No. _____

If spouse is the primary insured, spouse's employer: _____

IF SOMEONE OTHER THAN THE CLIENT IS RESPONSIBLE FOR PAYMENT, PLEASE

COMPLETE THIS SECTION:

Responsible Party: Dr./Mr./Ms. _____ Relation: _____

Address: _____ City, State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employed by: _____ Position: _____

Employer Address: _____ City, State: _____ Zip: _____ Employer Phone: _____

I understand that it is the policy of Amita H. Schmidt LCSW (dba Maui Psychotherapy) that I pay for my first visit and all future visits at the time service is rendered, unless prior arrangements have been made. I am responsible to know and understand the terms and conditions of my health insurance coverage. I also understand that the information Amita H. Schmidt LCSW (dba Maui Psychotherapy) receives from my insurance company is never guaranteed and is used only as a guideline. I agree to be responsible for all copayments, deductibles, non-covered services and all services rendered after the maximum allowed by my policy has been reached.

I authorize payment of insurance benefits to Amita H. Schmidt LCSW (dba Maui Psychotherapy) for all provided services.

I hereby authorize the release of medical information to my insurance company as required for billing.

CLIENT or Guardian SIGNATURE

Date