maui PSYCHOTHERAPY
Amita Schmidt, LCSW
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CLIENT INFORMATION

Client's name: ____ Male / Female

Birth date: _______/_______/_______

Address: ____City, State: ___________________________

Zip:___________

Phone: Work_________________________________Cell ____

Can I leave a message? At work: Yes___ No___ On your cell: Yes___ No___ Text your cell: Yes___ No___

Email: ______________________________________

Client's Employer: ____Position:_______________

Employer Phone: _________________________

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Spouse name: ____Phone: ___________________

In case of emergency contact: ____________________________Relation____________Phone: ______________

MEDICAL INSURANCE INFORMATION

Subscriber Name: ____ ID:______________________

Primary 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.

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CLIENT or Guardian SIGNATURE Date