CLIENT INFORMATION

First Name | Middle Initials | Last Name | Dated

Address | Town | State | Zip

Single/Married/Other | Male/Female

Date of Birth | Marital Status (Circle) | Sex (Circle)

Employer or School Name (list full or part time) | Town | Job Title

Home Phone | Office Phone | Cell Phone | Emergency Contact & Phone

Referring Physician or Other Source

PRIMARY PERSON ON INSURANCE POLICY IF OTHER THAN CLIENT

First Name | Middle Initials | Last Name

Address | Town | State | Zip

DOB | Sex | Relationship to Client

Home Phone | Office Phone | Employer

SIGNATURES FOR _____
CLIENT NAME

PRIMARY INSURANCE If Applicable

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I am the client, or authorized representative

Signed_____Date

I authorize Payment of Medical Benefits to the servicing Provider of Services. I am the client, or authorized representative

Signed_____Date

SECONDARY INSURANCE If Applicable

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I am the client, or authorized representative

Signed_____Date

I authorize Payment of Medical Benefits to the servicing Provider of Services. I am the client, or authorized representative

Signed_____Date

TERTIARY INSURANCE If Applicable

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I am the client, or authorized representative

Signed_____Date

I authorize Payment of Medical Benefits to the servicing Provider of Services. I am the client, or authorized representative

Signed_____Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received Notice of Privacy Practices for the Office of Heidi Blackstun, MSW, LCSW, MBA.

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Signature of Client, if 18 years or older, or Authorized Representative Date