Today's Date: _____ Therapist: **ELIZABETH H. PILSON, LCSW-C**

PATIENT INFORMATION: (Please print)

Name: _____ DOB: _____ SSN: _____
(First) (MI) (Last)

Address: _____

City_____ State_____ Zip_____

Phone #: (H) _____(W) _____(C) _____

Email address: _____

Referred By: _____

Marital Status: Married Partnered Single Widow Separated Divorced

Employment: Full-Time Part-Time Unemployed Full-time Student Part-Time Student

Employer/School: _____

Spouse/Partner's Employer/School: _____ Spouse/Partner DOB: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Current Primary Physician: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

INSURANCE INFORMATION:

Primary Insurance Co: _____ Policy #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Group #: _____ Effective Date: _____ Employer Name: _____

Insurance Phone #: _____ Authorization #: _____

Patient Relationship to Insured: Self Spouse Partner Child Other

Person Responsible for Account: Patient Parent Other

Name: _____ DOB: _____ Phone #: _____

Secondary Insurance Co: _____ Policy #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Group #: _____ Effective Date: _____ Employer Name: _____

Insurance Phone #: _____ Authorization #: _____

AUTHORIZATION TO BILL INSURANCE:

I authorize Avid Medical Billing Services, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed: _____ Date: _____

(PATIENT OR AUTHORIZED PERSON'S SIGNATURE)