



**PATIENT INFORMATION**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell # \_\_\_\_\_ Home # \_\_\_\_\_ EMAIL: \_\_\_\_\_

Where may we leave a detailed message? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Referred by: \_\_\_\_\_

M \_\_\_\_\_ F \_\_\_\_\_ Marital Status \_\_\_\_\_

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relation to Subscriber \_\_\_\_\_

Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relation to Subscriber \_\_\_\_\_

Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is there someone you would like to authorize our office to speak with regarding scheduling and/or canceling appointments?

If Yes, please list name, contact number and relation. \_\_\_\_\_

I hereby authorize Mary Larson, LPC. to furnish my insurance company all information which the insurance company may request concerning my present illness. I hereby assign Mary Larson, LPC. all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said clinician for charges not covered by this assignment.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Legal Guardian