Anne Parente, LICSW, SEP

Personal information

Name:_____ Date of Birth:_____
Address:_____
_____
_____
Best Phone #:_____
Email Address:_____
Relationship status: Single__ Partnered__ Married__ Widowed__
Divorced__ Poly__
Student Status: Full-time___ Part-time___
Chosen Pronouns: _____

Insured/guarantor information

Insureds Name:_____ Date of Birth:_____
Address:_____
_____
_____
Phone #:_____
Employer:_____
Insurance Company Name:_____
Group #:_____
Insurance ID#:_____
PlanType: HMO____ PPO____ Medicare___ Supplemental___
Insurance Phone #: _____
Occupation(s):_____
*if there are other insurances to cover you, print information on next page
Copy of Insurance card Provided? Y_____, N_____

Referral information

Who referred you to me? Doctor __ Friend__ On-line__ Other__
Name? (if comfortable in giving this information)_____

Financial assignment and Agreement (Initial and Sign)

_____ I authorize any holder of medical information about me or the insured, to release to the Centers for Medicare or Medicaid Services, my insurance company or its agents any information needed to determine the benefits payable for related services.

_____I understand that I am wholly responsible for the portion of my bill considered by my insurance company to be my co-payment, co-insurance, deductible, or other charges not covered by insurance including non-payment for my failure to comply with insurance guidelines regarding prior authorization of treatment.

_____I understand there will be a charge for late cancellation (less than 24 hours) for failure to show for an appointment.

X_____Date_____

Signature of Guarantor/Insured

_____

_____

Intake date:_____PresentingDiagnosis_____