

Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ Apt # _____ City: _____ Zip Code: _____

Phone:(_____) _____ Email: _____

Emergency Contact: _____ Phone: (_____) _____

Referral Source: _____ Employer: _____

Medical Provider Name: _____ Phone: (_____) _____

Current or chronic health problems: _____

Regular medications: _____

Drug/Alcohol use: _____

Why are you seeking therapy at this time? _____

Expected outcome? _____

Is there anything else I should know about? _____

Insurance Information

Primary Insurance Carrier: _____ Secondary Insurance: Yes No

Provider Phone Number: (_____) _____ SSN# _____

Subscriber Name: _____ Subscriber's ID: _____

Subscriber's Relationship to the client: _____ Subscriber's DOB ____/____/____

Group # _____ Plan _____ Subscriber's Employer _____

I certify the statements above are accurate. By signing below I authorize, Treina Aronson, LMHC Psychotherapy to bill my insurance company electronically for the services I receive and to permit disclosure of my private healthcare information to my health care insurance plan if needed to approve or pay for treatment services.

Signature: _____ Date: _____

