Patricia Scott, Licensed Clinical Social Worker, Psychotherapist
Email: mermaidpls@gmail.com
Phone: 707-740-5069

Client Registration (Please Print) Client's Full Name_____ SS#:_____

Home Address:_____ City: _____ State: _____ Zip:_____

Gender/Sex: _____ Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email: _____

Are calls allowed at: Work? ___ Yes ___ No Home? ___ Yes ___ No Message Machine? ___ Yes ___ No

Note: Calls may be for confirming or changing appointments and will be used with discretion. Living Arrangement:

_____ Referral Source: _____

Occupation or School/Grade Level: _____Known Disabilities/Impairments:

_____

Spiritual/Religious Affiliation, if applicable:

_____

Primary Care Physician Information: Doctor's

Name_____Address_____ Phone #: _____

Payment Method: ( ) Private Pay ( )

Insurance Coverage Information: Policy Holder Name:

_____ Date of Birth: _____/_____/_____

Home Address if Different than above_____

Employer: _____ Policy #: _____

Plan Name: _____ Group/Plan #_____

Insurance Co. Address: _____ Phone #:_____

I understand that I am responsible for the full amount of my bill for services provided. I understand that it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance company the day and time services are provided. I authorize Patricia L. Scott, LCSW to release any information required to process insurance claims billed on my behalf and to be paid benefits, directly, for treatment and services provided to me and or my immediate family members. Client or Responsible Party Signature:

_____ Date:_____