Cindi Mack-Ernsdorff, MA, LMHC, LMFT, CDP

Patient Information Form
All Patient Information and Services are Confidential

Patient's Name ______________________________ Today's Date _______________

Address ____

City ________________________________ State ________ Zip _____________

Phone ____________________ Date of Birth _____________ Gender ☐ Male ☐ Female

SSN _______________________ Employer _________________________________

Complete this section if treatment is covered by Health Insurance:

Insurance Company _____________________________

ID number __________________________ Group number ____________________

I authorize the release of medical and other information necessary to process claims for payment. I understand my insurance is an agreement between the insurance company and myself. If they do not pay for services rendered, I understand I am responsible for the bill along with costs incurred due to collections, attorney fees and/or court costs.

Patient Signature: ____________________________________ Date: ________________

Deductible amount: ____________ Deductible payment per session amount:___________
Co-Pay: ______________________

This section to be completed by the Healthcare Provider:

Date of Initial Exam: ___________________

DX Codes: __________ __________ __________ __________ __________ __________

Quick Claims Processing Fax: 612-395-9122