Personal Face Sheet Information Form

Therapist Name: Judith Meredith, LPC **Date:** ____________________

Patient Information: (REQUIRED)

Name: ______________________________ **Date of Birth:** ______________

SSN: ______________________ **Email Address:** ____________________

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ________________________ **Cell:** ____________________

Sex: M F **Marital Status:** Single Married Other

Insured Information: (This information is REQUIRED)

Patient Relationship to Insured: Self Spouse Child Other

Name: ______________________________ **Date of Birth:** ______________

SSN: ______________________ **Email address:** ____________________

Home Phone: ___________________________ **Cell:** _________________

Insured's Employer: ___________________________ **Phone:** __________

Insurance Company Name: ______________________ **Insurance phone:** __________

Policy/Member Number: ______________________ **Group #:** ____________

I hereby authorize the release of any medical or other information necessary to process claims for services rendered. I also authorize payment of benefits to the Therapist for all services rendered. I understand that I am responsible for any amount not covered by insurance.

Date: ______________________ **Signature:** ______________________
(Patient or Legal Guardian)