Patient Information

Name: ____________________

SSN: ____________________

Date of Birth ____________________

Mailing Address: ____________________

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How did you hear about our services?

Primare Care Physician

Psychology Today

Agency/Organization Workshop

Google

Family Member/Friend

Other (please name) ____________________

Home Phone: ____________________

Cell Phone: ____________________

Ok to leave message? Yes No

Sex: M F

Marital Status: S M D

Full Time Student: Yes No

Other:

Email: ____________________

School: ____________________

Grade: ____________________

Primary Insurance Carrier

Insurance Carrier Name: ____________________

Insurance Carrier Address: ____________________

Insurance Telephone: ____________________

Policy ID #: ____________________ Group #: ____________________

Policy Holder Name: ____________________ Policy Holder DOB: ____________________

Policy Holder Employer: ____________________ Copay Amount: ____________________

Policy Holder address if different than Patient's: ____________________

Secondary Insurance Carrier

Insurance Carrier Name: ____________________

Insurance Carrier Address: ____________________

Insurance Telephone: ____________________

Policy ID #: ____________________ Group #: ____________________

Policy Holder Name: ____________________ Policy Holder DOB: ____________________

Policy Holder Employer: ____________________ Copay Amount: ____________________

Policy Holder address if different than Patient's: ____________________

I Authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical/mental health benefits directly to Alyssa Najera, LCSW. I understand that if my insurance does not cover therapy that I will be responsible for any monies owed.

Therapist use only:

Dx: ____________________

Auth # ____________________

Visits # ____________________

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Signature of Patient or Responsible Party Date