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Dx: _____

Entered _____

PATIENT INFORMATION

Name _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone _____ Birth date _____ Age _____ Sex ___ F ___ M

Cell Phone _____ Business Phone _____ Employer _____

Occupation _____ Social Security Number _____ - _____ - _____

Person Responsible for Payment (*if other than patient*) _____

Address _____ City/State _____ Zip _____

Social Security Number _____ - _____ - _____ Relationship to Patient _____

In an Emergency Notify _____ Phone _____

If Insurance may cover part of these costs, please give the following information:

Insurance Company	Subscriber	Subscriber's Date of Birth	Subscriber ID#
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Phone	Claims Address	Group #
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Does your **mental health insurance** coverage require pre-authorization? _____

If yes, have you obtained this? _____ Authorization # _____

Number of visits authorized: _____

Secondary Insurance Company	Subscriber/Policy Holder	Subscriber ID#
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Phone	Claims Address	Group #
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Does this insurance company require pre-authorization? _____

If yes, have you obtained this? _____ Authorization # _____

Number of visits authorized: _____