NEW PATIENT INFORMATION

Rachel Zielinski, LCSW Today's Date: _____

PATIENT INFORMATION
Patient Name:
_____
(Last) (First) (Middle Initial)

Address: _____
(Street Name and #) (City) (Zip code)

Home Phone: (_____) _____ Date of Birth: _____
Marital Status: _____ Sex: □ Male □ Female
PCP Name: _____ PCP Phone: _____

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INSURANCE INFORMATION
Who is responsible for co-pays, deductibles, non-covered services and other balances: (please check only one) □ Patient □ other

Patient's Relationship to Guarantor/Policy Holder: □ Self □ Spouse □ Child □ Other

Policy Holder's Name (if other than self)

_____
(Last) (First) (Middle Initial)

Name of Insurance: _____ Policy Number: _____
Phone number on back of card: _____
Policy Holder's Date of Birth: _____

If your insurance requires you to have an authorization/referral, have you requested this from your PCP: YES NO

Do you have a second insurance where claims should be submitted? YES NO

If yes, what is the name of the insurance: _____
Policy #: _____

Phone number on back of card: _____
Policy holder's name: _____

Their relationship to you: □ spouse □ other: _____

In consideration of the provision of services to the above named patient rendered by Rachel Zielinski, LCSW I agree to be obligated to pay any remaining balance due not covered by my/patient's insurance carrier(s). I also agree to be obligated to pay any fees for missed appointments and canceled appointments with less than 24 hours' notice, as these types of charges are not billable to my insurance carrier. In addition, I authorize Rachel Zielinski, LCSW to release to parties responsible for payment of my/patient's mental health service bill(s) such information as may be necessary for the completion of financial obligation. All such transactions will be undertaken under conditions of strict confidentiality.

_____
(Patient Signature) (Date)

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