WENDY DOLIN, LCSW, LLC

Client Name:________________________________ **Date of Birth:** ______________

Billing Address:________________________________ **Marital Status:** S M W D

____

E-mail Address:___________________________ **Okay to send correspondence or statements?**____

If minor (under age 18) please write name of legal guardian:____________________________________

Social Security Number:______________________

Home Phone: ____________________ **Okay to call?**_______

Work Phone:_____________________ **Okay to call?**_______

Cell Phone:______________________ **Okay to call?**_______

Employer Name: _____________________________________ **City:**_____________________________

Primary Insurance:

Insurance Carrier:____

Phone Number:____

Identification Number:________________________ **Group Number:**_______________________

Subscriber Name: _____________________ **Subscriber Date of Birth:**________________________

Insurance Claims Mailing Address:____

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Secondary Insurance:

Insurance Carrier:____

Phone Number:____

Identification Number:_______________________ **Group Number:**__________________________

Subscriber Name:__________________________ **Subscriber Date of Birth**___________________

Insurance Claims Mailing Address:____

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Please read the following carefully and sign below:

I give permission to Wendy Dolin, LCSW, LLC and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles, and non covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed:____ **Date:**_____________________________