

BROOKHAVEN CENTER FOR COUNSELING AND DEVELOPMENT

Clinician: _____

Date of First Appointment: _____ Fee: _____

<p>Name: <i>(Last, First, Middle)</i></p> <p><i>Spouse/Partner (If requesting couples appts.)</i></p>	<p>Social Security Number (s):</p> <p><i>Self</i> _____</p> <p><i>Spouse/Partner</i> _____</p>
<p>Home Address: <i>(Street, Town, Zip)</i></p>	<p>Age (s): <i>Self</i> _____</p> <p><i>Spouse/Partner</i> _____</p> <p>Date of Birth: <i>Self</i> _____</p> <p><i>Spouse/Partner</i> _____</p>
<p>Mailing Address: <i>(If different from above)</i></p>	<p>Telephone:</p> <p>Home: _____</p> <p>Business/Cell: <i>Self</i> _____</p> <p><i>Spouse/Partner</i> _____</p>
<p>Occupation:</p> <p>Place of Employment:</p> <p>Address:</p>	<p>Student:</p> <p>Name of School:</p> <p>Location:</p>
<p>Family Physician:</p> <p>Address:</p> <p>Phone:</p>	<p style="text-align: center;">***INSURANCE INFORMATION***</p> <p style="text-align: center;"><i>(MUST BE COMPLETED IN ORDER TO BILL INSURANCE)</i></p> <p>Insurance Company:</p> <p>Name of Policy Holder:</p> <p><i>**Policy Holder's date of birth:</i></p> <p>I.D. # as listed on card:</p> <p>Group #:</p>
<p>Request for other ways of communicating with me:</p> <p>Please telephone me ONLY at this number:</p> <ul style="list-style-type: none"> ○ A message can be left on answering machine. ○ NO, never leave a message on my answering machine. ○ Messages can be left with anyone at this number. ○ NO, please speak with me only – NO messages are to be left with others at this number. <p>Please direct all mail to me at this address ONLY:</p>	
<p>Patient's Signature and Release <i>(If covered by Blue Cross/Blue Shield or Medicare)</i></p> <p>I authorize this office to provide my insurance company with any information necessary to process my claims. I understand that my signature below is my written permission for insurance payments for services rendered to be paid directly to the provider for services.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%; text-align: center;"> <p>_____</p> <p>Signature of Insured or Patient</p> </div> <div style="width: 30%; text-align: center;"> <p>_____</p> <p>Date</p> </div> </div>	