

Sheryl E. Woodhouse, LMFT

(949) 212-6228 / (949) 348-6944

PATIENT

Name/DOB: _____ Referred by: _____

Parents/DOB (if patient is a minor): _____

Address: _____ City: _____ Zip: _____

Phone No(s): _____

Phone Numbers if minor client:

Mother HM #: (____) _____ WK #: (____) _____ Cell #: (____) _____

Father HM #: (____) _____ WK #: (____) _____ Cell #: (____) _____

E-mail Address: _____ Driver's Lic #: _____

Social Security #: _____ Date of Birth: _____ Single Married Divorced

Employer & address: _____

Name of Relative: _____

Nearest Relative's Address/Ph. _____

INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Insured's Soc. Sec. #: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ Zip: _____

Insured's Employer _____

Employer's Address: _____ City: _____ Zip: _____

Insurance Co: _____ Phone #: (____) _____

Insurance Address: _____ City: _____ State: ____ Zip: _____

Policy #: _____ Group #: _____

Is there secondary insurance?

If so, please request a separate form for Secondary Insurance.

AUTHORIZATION (Signature on File)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill.

I authorize Sheryl Woodhouse, LMFT to act as **my** agent in helping to obtain payment from my insurance carrier(s).

I irrevocably authorize payment of medical benefits directly to Sheryl Woodhouse, MFT for services rendered to me.

I request payment of government benefits be made directly to Sheryl Woodhouse, MFT, who hereby accepts such assignment.

I permit a copy of this authorization to be used in place of the original.

Dated: _____

Signature: _____

Print Name: _____

DIAGNOSIS / COMMENTS

Diagnosis: _____ ICD-9 code: _____

COMMENTS:

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PATIENT: _____

SECONDARY INSURANCE

Name of Insured: _____	Relationship to Patient: _____
Insured's Soc. Sec. #: _____	Insured's Date of Birth: _____
Insured's Address: _____	City: _____ Zip: _____
Insured's Employer: _____	
Employer's Address: _____	City: _____ Zip: _____
Insurance Company: _____	Phone #: (____) _____
Insurance Address: _____	City: _____ State: ____ Zip: _____
Policy #: _____	Group #: _____

AUTHORIZATION (Signature on File)

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Dated: _____ Signature: _____

Print Name: _____