FAMILY COUNSELING CENTER -- PALM HARBOR & ST PETERSBURG

Diane HM Mandell MSSA, LISW, LCSW and Associates

Patient Information Sheet

General Information

Last Name: _____ First: _____ Middle: _____ Birth Date: ____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ F_____ M Marital Status: _____ Social Security #: _____ - _____ - _____

Employer: _____ Relationship to Insured: _____ Referred by: _____

Emergency Contact Name: _____ Relationship: _____ Phone #_____

Patient Contact Information: email Address: _____

Home Phone #: _____ May we leave a message? YES_____ NO_____

Cell Phone #: _____ May we leave a message? YES_____ NO_____

Work Phone #: _____ May we leave a message? YES_____ NO_____

Insurance Information-Primary Insurance

Authorization #_____

Insured's Last Name: _____ First: _____ Middle: _____Birth Date: ___/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____Sex: ___F___ M Marital Status: _____ Social Security #_____ - _____ - _____

Employer: _____ Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone #: _____ Policy/Subscriber Number: _____ Group Number: _____

Insurance Information-Secondary Insurance

Insured's Last Name: _____ First: _____ Middle: _____Birth Date: ___/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____Sex: ___ F___ M Marital Status: _____ Social Security #_____ - _____ - _____

Employer: _____ Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone #: _____ Policy/Subscriber Number: _____ Group Number: _____

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Coordination of Care

It is important for your health care providers to speak to each other, so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ Phone #: _____Fax #: _____

Address: _____City: _____ State: _____ Zip _____

May we contact your physician? ____YES ____ NO ____ I do not have a physician

Psychiatrist: _____ Phone #: _____Fax #: _____

Address: _____City: _____ State: _____ Zip _____

May we contact your psychiatrist? ____YES ____ NO ____ I do not have a psychiatrist

Assignment & Release: I hereby assign my insurance benefits to be paid directly to the undersigned therapist. I am financially responsible for non-covered services. I also authorize the therapist to release any information requested.

_____ _____

Client Signature or Authorized Parent/Guardian **Date**