Miriam Carmichiel, LCSW-R

New Patient Information

Today's Date:_____

PATIENT INFORMATION:

Patient Name:

_____
(Last) *(First)* *(Middle Initial)*

Address:_____

Home Phone: (_____)_____ Date of Birth: _____

Marital Status: _____ Sex: ☐ Male ☐ Female

PCP Name: _____ PCP Phone: _____

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 Number: _____

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 Miriam Carmichiel, LCSW-R I agree to be obligated to pay any remaining balance due not covered by my/patient's insurance carrier(s). In addition, I authorize Miriam Carmichiel, LCSW-R 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)*