Request for Psychological / Mental Health Services

To

R Jane Gould

Licensed Independent Clinical Social Worker

Date of Intake____________________

Please complete and bring to your first appointment

Name ____

Address ______________________________________

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Phone #s______________________________________

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Email ____

Social Security # __________________________

Date of Birth _____________________________

Gender _________ Marital Status ____________

Referring Physician ________________________

Reason for Consultation ____________________

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Primary Ins.________________________________

ID #_______________________________________

Group # ____________________________________

Name of Insured ____________________________

Relation to Insured _________________________

Address ___________________________________

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Phone _____________________________________

Secondary Ins ______________________________

ID # ______________________________________

Phone _____________________________________

Employer ___________________________________

Insurance Assignment Signature on File

I, ____, request that payment of authorized insurance benefits (including but not limited to Medicare, CIGNA, Carefirst BCBS) be made to R. Jane Gould, LICSW, LCSW-C for any services furnished to me by her. I authorize her or her office personnel to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. This authorization will remain in effect until revoked by me in writing.

Signature ____ Date ________________________

I acknowledge receipt of Notice of Privacy Practices (HIPAA)

Signature ____