Grace Riddell, LCSW-C, LICSW

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10027 Frederick Ave.
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PATIENT INFORMATION

Patient's last name:	First:	Middle:

Gender: ☐ Male ☐ Female ☐ Other	Social Security no.:	Birth date:	Age:

Street address:	Home phone no.:	Mobile phone no.:

P.O. box:	City:	State:	ZIP Code:

Email address:	Would you like to receive occasional emails with items of interest, including upcoming therapy groups or events? ☐ Yes ☐ No

Occupation:	Employer:	Employer phone no.:

Chose practice because / Referred by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Other

Partner/Spouse name:	Partner/Spouse Occupation:

PCP name and address:	PCP phone no.:

INSURANCE INFORMATION

Person responsible for bill:	Is this patient covered by insurance? ☐ Yes ☐ No	Home phone no.:

Insurance company:	Group no.:	Policy no.:

Insurance claims address:	Phone no.:

P.O. box:	City:	State:	ZIP Code:

IN CASE OF EMERGENCY

Emergency contact name:	Relationship to patient:	Phone no.:

Payment is expected at the time of service. I am responsible to provide a referral and/or authorization if required by my insurance company. I am responsible for remembering all scheduled appointments. All appointments must be cancelled at least 48 hours in advance by voicemail only. **Emails are not acceptable for cancellations or changes in appointments. Missed appointments and late cancellations are charged as FULL FEE.** Account balances must be paid within 30 days. Account discrepancies must be settled within 60 days. We are not responsible if your insurance does not pay or if they pay incorrectly. There will be a charge of $30 for any returned checks. Interest will be charged at the rate of 1.5% per month (18% annually) for any balance more than 30 days old. I acknowledge that I am fully responsible for payment of the total bill incurred and I will be responsible for paying costs of collection action and reasonable attorney's fees. I am responsible for payment for the amount not covered if my secondary insurance to my Medicare insurance does not pay the full amount.
AUTHORIZATION: By signing below this is authorization for Grace Riddell, LICSW, LCSW-C to apply for benefits on my behalf under Medicare or any private insurance company listed on this form. I further authorize the release of any necessary medical information for any claim to my insurance company, primary care physician or managed care network.

_____ _____

Signature of responsible party *Date*