Barbara Gold, LCSW, LMFT

Psychotherapy

Client Name: _____ DOB:_____Age:_____
First Middle Last

SS#: _____ Gender: ____ Relationship Status: _____ Phone #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone #: _____

Insurance Information

Primary Ins. Co.: _____ Phone #: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ SS#: _____ DOB: _____

Insurance Type: Group _____ Individual _____

Subscriber ID#: _____ Policy #: _____

Group Name: _____ Group #: _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

I understand that I am financially responsible for all charges. I hereby authorize Barbara Gold to release all information necessary to secure my reimbursement.

Client Signature: _____ Date: _____