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. In the event that benefits are assigned to Barbara Gold, the assignment shall remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. In the event that the insurance company does not pay for all charges, I understand that I am responsible for those charges. I hereby authorize Barbara Gold to release all information necessary to secure the payment.

Client Signature: _____ Date: _____

☐ Please send me email newsletters with updated information, resources, etc. if this box is checked by me. I understand that I can opt out of receiving newsletters by emailing or replying to bgoldlcsw@gmail.com with the word "unsubscribe" in the subject line.