MAUREEN LYONS TASHJIAN, MSW, LCSW

MEDICAL/INSURANCE INFORMATION

PATIENT: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: ____
INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
PHONE #: _____ MAJOR MEDICAL: YES__NO____
SUBSCRIBER ID #: _____ GROUP #: _____
CLAIM # (IF DIFFERENT FROM GROUP #): _____
ADDRESS WHERE CLAIMS SHOULD BE SUBMITTED (IF DIFFERENT FROM ADDRESS LISTED): _____
SUBSCRIBER NAME & ADDRESS (IF DIFFERENT FROM PATIENT): _____
_____
SUBSCRIBER SOCIAL SECURITY #: _____ DOB: _____
DOES INSURANCE COVER PSYCHOTHERAPY? _____
DOES YOUR INSURANCE HAVE A MAXIMUM # OF VISITS PER YEAR? YES___ NO___ IS IT PER CALENDAR YEAR? ___ ROLLING YEAR? ____
FAMILY PHYSICIAN NAME: _____
ADDRESS: _____
PHONE #: _____ HOSPITAL AFFILIATION: _____

SPECIALISTS:
NAME: _____ ADDRESS: _____
SPECIALTY: _____ PHONE: _____
HOSPITAL AFFILIATION: _____
NAME: _____ ADDRESS: _____
SPECIALTY: _____ PHONE: _____
HOSPITAL AFFILIATION: _____
MEDICATIONS:
_____
_____
_____
ALLERGIES (MEDICATION, FOOD, ETC.):
_____
_____
_____

(PLEASE SEE OTHER SIDE)

HAVE YOU PREVIOUSLY SOUGHT COUNSELING? YES_____ NO _____
ARE YOU PRESENTLY INVOLVED IN A WORKMAN'S COMPENSATION OR AUTO-ACCIDENT RELATED CASE? _____
IF APPLICABLE:
LAWYERS NAME: _____PHONE #_____
ADDRESS: _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE THE RELEASE OF ALL NECESSARY INFORMATION DURING THE COURSE OF MY TREATMENT, TO PROCESS INSURANCE CLAIMS AND TO MAINTAIN MEDICAL RECORDS. THIS OFFICE IS COMPLIANT WITH STATE AND FEDERAL HIPPA REGULATIONS IN ORDER TO INSURE YOUR PRIVACY.

Please indicate the name and number of an emergency contact person:
Name_____Date_____

Unless you have indicated otherwise the phone numbers you have provided will be used to leave call back messages.

SIGNATURE: _____

DATE: _____