

Patient Information

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____ Ext _____
Cell Phone _____ Pager # _____
eMail Address _____
Date of Birth _____ Social Security Number _____
Marital Status _____ Gender Male Female
Employer or School _____ Employment Status _____
Referred By _____ Religion _____
Race _____ Ethnic _____

Is the patient covered by insurance? Yes - Go to section II
 No - Go to section V on back page of this form

Section II - Insured Information

Patient Relationship to Insured: Self Spouse Child Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name _____
Address _____
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____
Date of Birth */ /* _____ Social Security Number _____
Marital Status _____ Gender Male Female
Employer or School _____ Employment Status _____

Section III - Insurance Policy Information

Medicare Medicaid ChampUS ChampVA Group Health Plan FECA Other

Insurance Company _____
Address _____
Address _____
City _____ State _____ Zip _____
Plan Name _____
Policy Number _____ Group Number _____

Is the patient covered by more than one insurance ? Yes - Please complete Section 4 - Page 2
 No - Please return this form to the Receptionist

(Over)

Section IV - Secondary Insurance Policy Information

Medicare Medicaid ChampUS ChampVA Group Health Plan FECA Other

Insurance Company _____
Address _____
Address _____
City _____ State _____ Zip _____
Plan Name _____
Policy Number _____ Group Number _____

Section V - Billing Information

(Complete only if there is no insurance coverage.)

Who is responsible for charges for this patient. Patient - Please return this form to the Receptionist.
 Other - Please Complete the following information.

Name _____
Address _____
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____
Date of Birth / / Social Security Number _____
Marital Status _____ Gender Male Female
Employer or School _____ Employment Status _____

Permission To Treat

I hereby give Thomas L. Haffner, LMFT, LLC permission to render treatment to myself and/or my dependent child/children.

Signature _____ Date _____

Payment

I authorize the release of any information to my insurance carrier(s) necessary to process my claims. I authorize my insurance company to pay benefits to Thomas L. Haffner, LMFT, LLC. I further agree to pay all non-covered expenses in accordance with the policies set forth and provided by Thomas L. Haffner, LMFT, LLC.

Signature _____ Date _____