General Client Information- Couples

Partner 1:

Full Name :_____

Birth Date:____/_____/_____ Age: _____ Gender: _____

Address: _____

_____

Home Phone: _____ May I leave a message? ☐ yes ☐ no

Cell: _____ May I leave a message? ☐ yes ☐ no

Work Phone: _____ May I leave a message? ☐ yes ☐ no

E-mail: _____ May I e-mail you? ☐ yes ☐ no

Emergency Contact Name/Relationship : _____

Emergency Contact Phone Number: _____

Name of Primary Care Provider: _____

Primary Care Provider Contact Information: _____

Initial below as indicated:

_____ I provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider for the purpose of case collaboration

_____ I do not provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider

Partner 2:

Full Name :_____

Birth Date:____/_____/_____ Age: _____ Gender: _____

Address: _____

_____

Home Phone: _____ May I leave a message? ☐ yes ☐ no

Cell: _____ May I leave a message? ☐ yes ☐ no

Work Phone: _____ May I leave a message? ☐ yes ☐ no

E-mail: _____ May I e-mail you? ☐ yes ☐ no

Emergency Contact Name/Relationship : _____

Emergency Contact Phone Number: _____

Name of Primary Care Provider: _____

Primary Care Provider Contact Information: _____

Initial below as indicated:

_____ I provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider for the purpose of case collaboration

_____ I do not provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider

What method of payment will be used? (Initial as indicated)

_____ I am paying out-of-pocket

_____I am using health insurance benefits

Health Insurance Company: _____

Name of Policy Holder: _____

Policy Holder D.O.B.: _____Relationship to client: _____

Insurance ID #: _____Group #: _____

Initial below as indicated:

_____: If self-paying:
I understand I am financially responsible for all services, charges, and fees

_____: If using insurance benefits:
I hereby authorize my insurance benefits to be paid directly to Cynthia Stanford, LMFT for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

Some find it convenient to put a credit card on file. This can be helpful when adolescents attend appointments alone, or when clients have busy schedules or late appointment times. Please note that **you are not required to provide this information.**

Cardholder Name: _____

Visa/Mastercard (please circle) Number: _____

Expiration: _____V-code: _____ Billing zip code: _____

I authorize my credit card to be billed by Cynthia Stanford, LMFT, for all copays, fees, and services rendered that are not covered by my insurance company

_____
Cardholder Signature

_____ _____
Signature of Partner 1 Date

_____ _____
Signature of Partner 2 Date