

Susan Corbett, LCSW, BCD

4067A South Tamiami Trail, Sarasota, FL 34231 (941) 926-8080 FAX: (888) 664-2547

INFORMATION SHEET

Date: _____ Home Tel. _____ Work Tel. _____ E-mail _____

Name: (Print) _____ Social Sec. # _____

Insurance Company ID #: _____

Address: _____ City/State/Zip _____

Date of Birth _____ Age _____ Sex: _____ Marital Status: S _____ M _____ D _____ Partner _____

Occupation: _____ Employer (Print) _____

Insurance Information (Please Print)

EAP Name: _____ Telephone _____

Insurance Co. Name: _____ Telephone _____

Claims Address _____

City: _____ State: _____ Zip _____

Account # _____ Group # _____

Authorization Number _____ Co-Pay Amt. _____

Insured Name (if different) _____ Relation to patient _____

Insurance Co. Name: _____ Telephone _____

Claims Address _____

City: _____ State: _____ Zip _____

Account # _____ Group # _____

Authorization Number _____ Co-Pay Amt. _____

Employer _____

Home Address: _____ City/State Zip _____

Soc. Sec.# _____

Date of Birth : _____ Age: _____ Sex : _____ Telephone: _____

ASSIGNMENT AND DISCLOSURE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits payable to provider indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of my signature is as valid as the original.

CANCELLATION: We set aside a specific time for you. If you should cancel, every effort will be made to re-schedule during that same calendar week. Otherwise, the full fee will be charged.

If you wish further information about your legal privacy rights, you may receive a written copy of your privacy rights, upon request. The privacy rights are also posted in the waiting room.

Signature of Insured

Date

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Last Name _____ (page 2)

Briefly describe your reason for contacting me now: _____

_____ How long has this been a problem? _____

Has this affected your: (Mark with X those that apply):

MOOD: ANXIETY___ SADNESS___ ABILITY TO CONTROL ANGER___ CONCENTRATION___

MARRIAGE/PARTNER/FAMILY___ CHILD REARING___ EATING/SLEEPING HABITS ___

JOB/SCHOOL/PERFORMANCE___ FINANCIAL SITUATION___ LEGAL SITUATION___

Have you had prior therapy? _____ Reason _____ How long? _____

Any Current Drug/Alcohol use? _____ If so, do you feel it might be a problem? _____

If you have children, what are their names and ages? _____

We are legally required to ask you the following:
Do you ever feel like hurting yourself, or have suicidal impulses? _____
Do you sometimes feel like causing physical harm to others? _____

Current medical problems: _____

What medications, if any, are you taking? _____

What do you hope to accomplish here? _____

Note 1: Treatment plan and discussions regarding diagnosis and treatment plan are strictly confidential. No information will be released without your written consent, with the exception of information and documentation required for further treatment authorization by your insurance company.

Note 2: Occasionally we would like to contact you directly by email about special workshops that we are conducting that we feel you may benefit from. Is this alright with you? Yes; ___ No. ___

I understand and consent to the above declaration:

Patient Signature Date