Susan Chamberlin, LMHC
28 Green Street
Newbury, MA 01951
978-462-0166

Today's Date:_____

Who Referred You?:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code:_____

Marital Status:_____ Social Security #: _____

Phone #'s: H:_____ W:_____C:_____

Emergency Contact:_____ Phone #:_____

May I call you and leave messages at these phone #'s? Yes_____ No_____

INSURANCE INFORMATION

Employer:_____ Occupation:_____

Insurance Company:_____ Co-payment:_____

Insurance Company Mental Health Phone #:_____

Insurance ID#:_____ Group#:_____

Insurance Company Address:_____

Subscriber's Name:_____ Date of Birth:_____

Relationship to Subscriber:_____ Responsible Party for Bills:_____

PATIENT'S OR AUTHORIZAED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED:_____ Date:_____

INSURED OR AUTHORIZED PERSONS SIGNATURE: I authorize payment of medical benefits to Susan Chamberlin, LMHC for services described.
SIGNED:_____ Date:_____

Clinician:_____ DX:_____ TX Modality_____