Counseling Services Inc

1605 John Street, Fort Lee, NJ 07024

Patient Information

E-mail Address

Last Name, First Name

Patient Address

Day Phone

Evening Phone

City, State Zip

Date of Birth

Sex

Relationship Status

Social Security #

Employer

Emergency Contact

Emergency Day Phone

Evening Phone

Responsible Party

Last Name, First Name

Address

Day Phone

Evening Phone

City, State Zip

Date of Birth

Sex

Relationship Status

Social Security #

Employer

Emergency Contact

Emergency Day Phone

Evening Phone

Insurance

Company

Insured Party

Relationship

Plan Name

Effective Date

Policy Number

Group Number

Insurance Company Provisions; Authorization #;

Please Specify Number Of Visits If Applicable

Authorization for release of information, and third party payment

I request that payment of authorization benefits be made either to me on my behalf to Counseling Services Inc. I authorize any holder of medical information about me to release this information in support of determining these benefits payable for related services. I assign all insurance benefits for treatment to be paid directly to the above named provider. I certify that any copy of this form shall be accepted as valid as the original.

Patient Signature

Responsible Party Signature [if not applicant]

Date

"Talking is healing and healing takes time..."

CONFIDENTIAL