Donna G Wright, LPC

CLIIENT INFORMATION

Patient Name: First _____ MI ____ Last _____

Address: _____ City _____ State _____ Zip _____

Home Number: _____ Work Number: _____ Cell Number: _____

Sex: M ___ F ___ Date of Birth: _____/_____/_____ Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Social Security Number: _____ Student: Full Time? ____ Part Time? ____

Driver's License Number: _____ State: _____ **E Mail**: _____

Employer: _____ Employed: Full Time ____ Part Time ____

Employer's Address: _____ City _____ State _____ Zip _____

Employer's Phone Number: _____ Occupation: _____

Name of Nearest Relative: _____ Relationship: _____

Relative's Address: _____ City _____ State _____ Zip _____

Relative's Phone Number: _____

Primary Care Doctor: _____ Phone Number: _____

Accident/Injury? Yes ___ No ___ If so, date? _____ Auto? Yes ___ No ___ Work Related? Yes ___ No ___

This information is now required to process your claims for payment. Please select the appropriate one that identifies you. Please answer all 3 questions:

Race: Please circle one: Caucasian Black Asian American Indian or Alaskan Pacific Islander Other race Declined

Ethnicity: Please circle one: Hispanic or Non Hispanic Declined

Language: Please circle one: English Arabic Cantonese French German Hindi Italian Japanese Korean Polish Portuguese Spanish Other

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INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Policy Number: _____ ID Number: _____

Insured: _____ **DOB** _____ Relationship: Self _____ Spouse _____ Parent _____

Secondary Insurance Company: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Policy Number: _____ ID Number: _____

Insured: _____ Relationship: Self _____ Spouse _____ Parent _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay for all charges or any deductible amount, co-insurance, or any balance not paid for by my insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign to Donna G Wright, LPC, all medical and/or surgical benefits, including major medical benefits, Medicare, private insurance, and other health plans to which I am entitled. My assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I authorize medical treatment.

SIGNATURE: _____ DATE: _____