Jessica Giordano
LMFT, LADC
Holistic Psychotherapy & Wellness Counseling

Client Information Sheet

Name: _____

DOB: _____ Social Security Number: _____

Address: _____
(Street) (Town) (State) (Zip code)

Home Phone #: _____ Cell Phone #: _____

Best # to be reached at: (circle one) Home Cell

Emergency Contact: (in the case of a medical emergency, who could be contacted on your behalf)

Name: _____ Phone #: _____

Relationship to you: _____

Insurance Information:

Primary Insurance: _____ Effective Date: _____

ID #: _____ _____ Group #: _____ Policy Holder's DOB: _____

Policy Holder's Name: _____ Relationship to Client (circle one)
Self Spouse Parent Other

Policy Holder's Employer: _____ Full Time or Part Time (circle one)

Secondary Insurance: _____ Effective Date: _____

ID #: _____ _____ Group #: _____ Policy Holder's DOB: _____

Policy Holder's Name: _____ Relationship to Client (circle one)
Self Spouse Parent Other

Policy Holder's Employer: _____ Full Time or Part Time (circle one)

Assignment of Insurance Benefits: I hereby authorize direct payment of medical benefits to the provider, Jessica Giordano, LMFT, LADC. I understand that I am financially responsible for any balance not covered by my insurance provider.

Authorization to Release Information: I hereby authorize the provider, Jessica Giordano, LMFT, LADC to release any medical information necessary to process my insurance claim and determine benefits payable.

Medicaid: I hereby authorize payment of Medicaid benefits to be made to the provider, Jessica Giordano, LMFT, LADC on my behalf for services rendered. I authorize the release of any medical information needed to determine benefits payable.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____