Amy M. Rosenthal
Licensed Clinical Social Worker
929-382-4251
https://www.arosenthallcsw.com/

Patient Information

Date: ________________________

Client Name: ____________________________________ Date of Birth: ________________________

Employment Status: ______________________ Relationship Status: __________________________

Gender Identification/Pronouns: ____

Current Address: ____

City: _________________________________ State: _________ ZIP+4 Code: ___________________

Mailing Address: ____

City: _________________________________ State: _________ ZIP+4 Code: ___________________

Permanent Address (if different): ____

City: _________________________________ State: _________ ZIP+4 Code:____________________

Contact Information:

Home #: ____________________ Work #: _____________________ Mobile #: _______________

I hereby authorize therapist or administrator to contact me and/or leave messages on my (please circle): home/ work /mobile phone(s).

Please specify any privacy preferences/concerns:

____

Email Address:

____

I hereby authorize therapist or administrator to contact me via (please circle): email /text.

Please specify any privacy preferences/concerns:

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Responsible Party (statements will be provided to):

Name: _________________________________ Date of Birth: ___________________________

Relationship to Client: ____

Gender Identification/Preferred Pronouns: ____

Address: ____

City: ______________________________ State: _________ ZIP+4 Code: __________________

Contact Information:

Home #: ___________________ Work #: ___________________ Mobile #: ______________

I hereby authorize therapist or administrator to contact and/or leave messages on this party's (please circle): home/ work /mobile phone(s).

Please specify any privacy preferences/concerns:

____

Email Address:

____

I hereby authorize therapist or administrator to contact this party via (please circle): email /text.

Please specify any privacy preferences/concerns:

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Insurance Information

Primary Insurance:

Insurance Company: ______________________________ Phone #: _________________________

Subscriber’s/Insured's Name: _____________________________ Date of Birth: ______________

Employer: ____

Location of Employer or Origin of Insurance: ____

Subscriber’s ID: ___________________________________ Group #: ________________________

Coverage Start Date: ____________________ Coverage End Date: _________________________

Copay Amount: ____

Secondary Insurance:

Insurance Company: ______________________________ Phone #: _________________________

Subscriber’s/Insured’s ID: _______________________________ Group #: ___________________

Coverage Start Date: ____________________ Coverage End Date: _________________________

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.

Authorization to Release Information:

I hereby authorize the release of any information needed to determine insurance coverage or benefits payable for related services regarding my/my child’s condition or treatment to my insurance company and its agents.

Authorization to Pay Insurance Benefits to the Provider:

I hereby authorize the payment of insurance benefits from my insurance company to my provider.

If for any reason my insurance company does not make payment(s) on a legitimate claim for services, I will assume responsibility for payment.

I, the undersigned, accept that it is my responsibility to inform Amy M. Rosenthal, LCSW of any changes to my insurance or benefits, including a change to a new insurer, or change of co-payment amount or deductible. If I do not inform her, I will be responsible for covering any and all such fees not covered by my insurance.

SIGNED: ____ DATE: _______________________

Client's Name/Legal Guardian's Name (Please print):

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Waiving Use of Insurance Benefits

Please note that Amy M. Rosenthal, LCSW accepts **Cigna** insurance as an *in-network* provider. Some clients prefer not to use their insurance benefits for various reasons, such as to maintain full confidentiality and/or autonomy over their treatment, and prefer to pay out of pocket. If you wish to do so, please sign below to acknowledge that you have insurance coverage and choose not to use it, and understand that in doing so you waive any right to reimbursement.

SIGNED: ____ DATE: ________________________

Client's Name/Legal Guardian's Name (Please print):

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