Last Name:	First Name:	Middle Initial:
Chosen Name:		
Assigned Sex (for Insurance Billing): Female ☐ Male ☐ Preferred Gender: Preferred Pronouns:	Phone Number (Preferred): May we leave a message: Yes ☐ No ☐ Phone Number (Secondary): May we leave a message: Yes ☐ No ☐	
Address, City & State, ZIP Code		

Marital Status:	Date of Birth (MM/DD/YYYY):	Age:

Employment Status of Client: Employed ☐ Retired ☐ Disability ☐ Other ☐ _____ Employer:	Student Status of Client: Full-Time ☐ Part-time ☐ N/A ☐ School:

In Case of Emergency:

Name:	Relationship:
Phone: Email:	

Who referred you to the Anxiety & Stress Center?

Are you involved in any current or pending civil or criminal litigation(s), lawsuit(s) or divorce or custody dispute(s)? Yes ☐ No ☐ If you answer yes, please explain:

Signature on File

I understand that I am responsible for my bill.
I authorize use of this form for all my insurance submissions.
I authorize release of necessary information to all my insurance companies.
I authorize Anxiety & Stress Center, P.C. and its billing service to act as my agent in helping me obtain payment from my insurance companies.
I authorize direct payment to Anxiety & Stress Center, P.C.
I permit a copy of this authorization to be used in place of the original.
I understand that if my insurance does not pay for services rendered, I am responsible for my entire bill.

Client Signature Printed Name Date

Guardian Signature (if client is under 18) Printed Name Date

Coordination of Care

In an effort to coordinate your care, we routinely correspond with referring and treating physicians, including primary care physicians, gynecologists, internists, psychiatrists, and others. Please fill out the form below so that we may send summaries of treatment to your physician. Your signature below gives us permission to correspond with your treating physician while you are receiving services at the Anxiety & Stress Center, P.C. You may revoke this permission at any time.

Physician's Name _____

Address_____

_____

City State Zip

Phone _____ Fax _____

Client Signature Printed Name Date

Guardian Signature (if client is under 18 Printed Name Date