**LICIA GINNE, PsyD., MFT**

## Individual Information

Date:_____

Client:_____

☐Single ☐married ☐co-habit ☐ divorced ☐separated ☐widowed

Home address:_____

City_____zip_____

Date of Birth_____ Age_____

Tel: Home:_____work_____Cell_____

Email_____

Preferred contact: ☐home ☐work ☐cell ☐email (check as many as you wish)

Employer_____Occupation_____how long_____

Person to contact in emergency_____
name

_____
Address phone

Referred by:_____

**If you would like me to submit an insurance claim for you, please fill out below information and a copy of the front and back of your insurance card.**

Insured Person: _____ Relationship_____

Employed By_____Birth Date:_____

Address of Insured Person_____

_____

Insurance Co:_____Policy/Group#_____

Insured ID#:_____Insurance Phone#_____

Claims Address:_____

**In signing this agreement my signature acknowledges that I fully agree to and accept the following conditions:**

- I authorize the release of medical or treatment information necessary to process my insurance claim including the release of a mental or chemical dependency diagnosis.
- I accept full responsibility for payment should my insurance carrier not reimburse for services rendered. I understand and accept all financial responsibility for treatment.

Client Signature_____Date_____

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