

INTAKE INFORMATION

For all persons seeking treatment (Please * the name for whom we will bill):

Name	DOB	Contact #'s (home/work/cell)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City/State/Zip _____

Insurance Info

Identified patient's marital status: _____ **Gender:** _____

Insured: _____ **Insured's employer:** _____

Insured's relationship to patient: _____ **Insured's DOB** _____

Insured's address: _____

City/State/Zip: _____

Insured's ID #: _____ **Group #:** _____

Insured's SS#: _____ **Insurance Co:** _____

Insurance Co. address: _____

City/State/Zip: _____

I hereby consent to any exchange of information necessary between Cynthia A. Schendel, LCSW, any billing agent she employs and my insurance company for the purpose of processing my claim. I also request payment of government or private benefits to myself or to the party who accepts assignment on this claim. I authorize payment to Cynthia A. Schendel, LCSW for the services she provides.

_____ **Date** _____