Lynda Green-Alter, MFT
4 Venture, Suite 230, Irvine, CA 92618
Phone: (949) 453-9600 FAX: (949) 453-9601

P A T I E N T

Name: _____ Referred by: _____

Home Address: _____ City: _____ Zip: _____

Telephone Numbers: home #: (____) _____ cell # (____) _____ work #: (____) _____

Employer's name & address: _____

Social Security #: _____ Date of Birth: _____ Single / Married / Divorced

Driver's License **#**: _____ Email Address: _____

Emergency contact: Name: _____ Phone #: _____

I N S U R A N C E

Name of Insured: _____ Relationship to Patient: _____

Insured's Soc. Sec. **#**: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ Zip: _____

Insured's Employer: _____

Employer's Address: _____ City: _____ Zip: _____

Insurance Company: _____ Phone #: (_____) _____

Insurance Company's Address for Claims: _____ City: _____ State: ___ Zip: _____

Policy #: _____ Group #: _____

Is there secondary insurance? _____ If so, please also fill out the separate form for Secondary Insurance.

AUTHORIZATION (Signature on File)

Patient hereby agrees to a No Show or Late Cancellation fee of $ 175.00 _____ (patient's initials)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill.

For any schedule appointments that I do not show up OR I cancel with less than 24 hours prior notice, I acknowledge that I will be charged and will be personally responsible for a **$175** charge.

I authorize **Lynda Green-Alter, MFT** to act as **my** agent in helping to obtain payment from my insurance carrier(s).

I irrevocably authorize payment of medical benefits directly to **Lynda Green-Alter, MFT** for services rendered to me. I request payment of government benefits be made directly to **Lynda Green-Alter, MFT**, who hereby accepts such assignment. I permit a copy of this authorization to be used in place of the original.

Dated: _____ Signature: _____

Print Name: _____

DIAGNOSIS / COMMENTS

Diagnosis: _____ ICD-10 code: _____

COMMENTS: