Lynda Green-Alter, MFT
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(949) 453-9600 FAX #: (949) 453-9601

PATIENT INFO UPDATE - 2021

PATIENT'S NAME: _____

		Yes	**No**
1.	Has your mailing or email address or telephone number(s) changed?	____	____

If so, please note the new information below:

Mailing Address: _____

_____

Circle One:

Home Phone:	(_____) _____	OK to leave message?	Yes / No
Cell Phone:	(_____) _____	OK to leave message?	Yes / No
Work Phone:	(_____) _____	OK to leave message?	Yes / No
Email Address:	_____ _____	OK to send emails?	Yes / No

		Yes	**No**
2.	Has your insurance information changed?		
	If so, please note the new information below:	____	____

Insurance Company Name: _____
Insurance Co. Phone #: (_____) _____
Policy Holder's Name: _____ DOB: _____
Group Number: _____
Member / ID Number: _____
Date Insurance is effective: _____

3. Who should we call in the event of an emergency?

Name: _____ relationship to you: _____
Telephone Number: (_____) _____

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, even if insurance refuses to authorize treatment or pay claims. I am aware of the $175 fee for missed appointments or those cancelled after 5pm the business day prior to the appointment. I authorize **Lynda Green-Alter, MFT** to act as my agent in helping me obtain payment from my insurance carriers. I irrevocably authorize payment of medical benefits directly to **Lynda Green-Alter, MFT** for the services rendered to me. I request payment of government benefits to **Lynda Green-Alter, MFT,** who accepts such assignment. I permit a copy or fax of this authorization to be used in place of the original.

Dated: _____ _____
Signature of Patient (or guardian)