# SARAH DIONNE,LICSW
# CLIENT INTAKE AND MASTER FORM

II. **PATIENT DATA:**

Name: _____
Last First
Middle Initial

Address: _____ Sex ☐ Male ☐ Female

_____ **Birthdate**: _____/_____/_____

City: _____ **Social Security** #_____

State: _____ Zip: _____ **Diagnosis:**_____

**Home Phone**: ( )_____

**Cell Phone:** ( ) _____ **Work Phone:** ( ) _____
**EXT** ____

**LEGAL GUARDIAN**: _____ **Phone**: ( ) _____

**E-MAIL ADDRESS:**_____**INT.**._____

III. **INSURANCE AND BILLING DATA:**

Marital Status: _____

Subscriber Name: _____**DOB**_____

Address (if different from patient): _____

Phone: ( ) _____

Policy Number: _____Authorization #:_____

PRIMARY CARE
PHYSICIAN_____TELEPHONE_____

**Billing info**: I hereby authorize my insurance benefits to be paid directly to **Sarah Dionne, LICSW** for the medical services rendered. I also authorize **Sarah Dionne, LICSW** to release any information necessary to process this claim. I understand that it is my responsibility to obtain the proper referrals from my health plan or Doctor. I agree to accept full responsibility for fees owed to **Sarah Dionne,** if a referral is not in place at the time of my visit or if, for any other reason my health plan does not cover my fees. If I cancel a scheduled session within 24 hours of that appointment, I agree to pay ~~**$65.00**~~ $125.00 for the session missed. I further authorize contact with my primary care physician to coordinate care.

**CLIENT OR GUARDIAN**:_____

**Signature:** _____ **Date**: _____