

Michele Saffier, LMFT, CSAT

Licensed Marriage and Family Therapist

Patient Information

Name:	_____
Age:	_____
Gender:	_____
Date of Birth:	_____
Social Security #:	_____
Home Phone:	_____
Work Phone:	_____
Cell Phone:	_____
Address:	_____
Street:	_____
City:	_____
State:	_____
Zip:	_____
E-mail:	_____
Marital Status:	_____
Education:	_____
Occupation:	_____
Referred by:	_____
Employer:	_____
Address:	_____
Emergency Contact:	_____
Phone:	_____
Family Physician:	_____
Phone:	_____
Address:	_____
City:	_____
State:	_____
Zip:	_____

Spouse / Parent Information

Spouse / Parent:	_____
Who has primary Guardianship:	_____
Occupation:	_____
Spouse/Parent Employer:	_____
Work Phone:	_____
Address:	_____
Street:	_____
City:	_____
State:	_____
Zip:	_____

Insurance Information

Insurance Company Name:	_____
ID #:	_____
Type of Insurance:	_____
Claim #:	_____
Adjuster or Contact:	_____
Phone:	_____
Address:	_____
Street:	_____
City:	_____
State:	_____
Zip:	_____
E-mail:	_____

Our office policy requires payment at the time of service unless otherwise arranged. A 24 hour notice of cancellation is required in order to avoid being charged for a missed appointment.

By my signature below, I consent to the release of information as necessary for collection of services being billed.

Name: _____ Signature: _____ Date: _____