

Welcome_____

Please complete all pages including claim form for insurance. All your information is CONFIDENTIAL!!! Kindly have check to Michele Lane ready before session.

Thank you

Patient Name_____Insured Name_____SSN#_____

D.O.B._____age____Insured DOB_____Employer_____

Co-payment____Group#____Deductible_____

Home Address_____

Home phone_____work_____cell_____e-mail_____

Couple's Spouse/Partner

name_____DOB____age____Home#____wk#_____

#years married____,Living together__

Patient-divorced-#times____, years____, separated#times____,years____

Children#____, names____,age____,grade

names____,age____,grade in school____

Names____age____grade in school____

Previous Counseling ? yes____no____, when____. with whom____

How did you find Michele Lane LMSW-ACP? provider directory____,Dr____,friend____

SWhouston yellow Pages____, Sugarland Directory____, Galleria____,Internet____,

G&L yellow pages____referred by manaage care_____

All fees and or co-payments are payable in advance. I understand that if my insurance company does not reimburse Michele Lane for each session of psychotherapy, I will be responsible for all unpaid sessions.

Signature_____

I understand that if I am to cancel an appointment, I must give Michele Lane at least 24 hours notice in advance. Otherwise I will be charged \$50 for each session missed without advanced notice. signature_____

I authorize release of information to my Doctor_____who is located at _____-

.telephone#_____. signature_____ Medication_____