sherradbarton
LICSW, LADC I

Registration Form

Date: _____

Information

Last Name : _____ First Name: _____ Middle: _____

DOB : _____/_____/_____ Age: _____ Gender: M F Email: _____

Address: _____City: _____ State: _____ Zip:_____

Phone: _____-_____-_____ Cell: _____-_____-_____ Work: _____-_____-_____ EXT: _____

Insurance Information

Subscriber: (Self) (Spouse) (Parent) (other) Name of Subscriber: _____

Primary Ins: _____ Policy #: _____ Group #: _____

Social Security Number: _____-_____-_____

Managed Plan: Effective Date_____/_____/_____ # of Sessions in Benefit Plan_____ Co-pay =$_____

Secondary Ins: _____ Policy #: _____ Group #: _____

Number of out-patient Mental Health visits/sessions used during calender year:_____

Dates of sessions: _____

Authorization to Release Protected Health Information to Insurance Company

I hereby authorize Susan Sherrad Barton, LICSW, LADCI to furnish Protected Health Information to my health insurance company for the purposes of authorizing care, filing claims for payment or complying with insurance company requirements regarding the management of my care.

_____ _____/_____/_____
Name (Printed) Date of Birth

_____ _____/_____/_____
Signature Today's Date

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Referral Information

How did you hear about us?_____

_____

Have you been given a diagnosis? _____

_____

Name of Diagnosing doctor/clinician _____ Year(s) treated _____

What type of treatment have you sought for the diagnosis?_____

_____

Are you currently on any psychotropic medication? Anxiety? Mood stabilizer? Depression Medication?

Current Medications/Dose:

_____

_____

_____

_____

Who prescribes the medication (PCP/Psychiatrist? _____

*** For coordination of care purposes:

May I contact the prescriber? _____ Contact number for treating prescriber _____-_____-_____

(If answers are all "no" to the above questions please answer, the following question)

Reason for Seeking Treatment: _____

_____

_____

_____