Patient Name, Nickname, and Preferred Pronouns:
Street Address: City, State, Zip:
Phone:
Email:
Date of Birth:
Marital Status:
Employment/School Status:
Primary Insurance Company Name, ID, and Phone Number:
Secondary Insurance Company Name, ID, and Phone Number:
Employee Assistance Program Name, Phone Number, and Authorization:
Subscriber - If someone other than you is the subscriber of any of the above policies, please provide their name, address, phone, date of birth, relationship to you, and which policy they are the subscriber for:
Emergency Contact Name and Number:
Primary Care Doctor Name and Number:

Consent to Release of Information, Authorization of Payments, and Responsibility for Payment

I hereby authorize Stef Coleman, LMFT to release any information necessary to facilitate the processing of insurance claims submitted on my behalf for services she renders to me. I hereby authorize payment of insurance benefits to Stef Coleman, LMFT for services she renders to me. I understand that this authorization will remain in effect unless I terminate the authorization in writing. I understand that I am responsible for knowing my insurance benefits and paying deductibles, co-payments and non-covered services.

Treatment Agreement and Privacy Policies

I hereby acknowledge that I have received a copy of this office's Treatment Agreement and Notice of Privacy Policies (available online at stefcoleman.com or by email at my request) including cautions about using text and email for communicating about private health information. I understand and agree to comply with them.

Cancellations, Co-Payments, Deductibles

I understand and agree that two business days notice is required for cancellation of a session. I will pay for any missed sessions or sessions canceled late as per my insurance company's regulations. Insurance will not be billed for those sessions.

Signature:_____ Date:_____