Marjorie F. Milstein, LCSW
LCS6768 ■ (619) 543-1133 office ■ (619) 543-0711 fax
www.marjoriemilsteinlcsw.com

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE (HOME): _____ PHONE (WORK): _____

PERMISSION TO LEAVE MESSAGES: HOME Y N WORK Y N

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: S M W D Sep

NAME OF SIGNIFICANT OTHER _____ RELATIONSHIP _____

OCCUPATION: _____

PERSON TO NOTIFY IN EMERGENCY: _____ PHONE: _____

PRIOR MENTAL HEALTH TREATMENT? Y N APPROXIMATE DATES: _____

NAME(S) OF PROVIDER(S): _____

PRESENT MEDICAL CONDITIONS: _____

CURRENT MEDICATIONS: _____

REFERRED BY: _____

INSURANCE INFORMATION:

1. MEDICARE OR MEDI-CAL NUMBER _____

2. CHAMPUS: Sponsor's Name: _____ Service No. _____

Retired/Active _____ Prime/Standard _____

3. OTHER INSURANCE: Name of Company _____

Address _____

Insured Employee _____ Name of Group Employer _____

Grp/Policy No. _____ Memb/Cert No. _____

INSURANCE INFORMATION AND PAYMENTS: I hereby authorize the above-indicated insurance company to pay directly to Marjorie Milstein, LCSW, any insurance payments otherwise payable to me for services rendered and I agree to pay the balance which is not covered by insurance payments. I also authorize Marjorie Milstein, LCSW, to release any information requested by the insurance company which might be needed to process this claim.

Signature _____ Date _____

The undersigned agrees to reimburse Marjorie Milstein, LCSW, for professional services. I understand I will be charged for cancelled appointments unless cancellation is at least 24 hours in advance or is due to an emergency.

Client/Guardian Signature _____ Date _____ Fee _____

Confidentiality: I understand that all information between myself and my therapist is held strictly confidential and my therapist will not release any information about me or my therapy unless permitted or dictated by law or I agree in writing to permit such a release.

Mailing address: 302 Washington Street, # 207, San Diego, CA 92103