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Wakefield, RI 02879

Patient Information

Patient Name: _____ **Date of birth:** _____

Street address: _____

Town: _____ **State:** _____ **Zip code:** _____

Telephone: _____ **Other phone, work/cell:** _____

Primary Insurance: _____ **Policyholder's Name:** _____

Policy Number: _____ **Policyholder's date of birth:** _____

Relationship to patient: self spouse parent step-parent

Employer: _____

Secondary Insurance: _____ **Policyholder's Name:** _____

Policy Number: _____ **Policyholder's date of birth:** _____

Relationship to patient: self spouse parent step-parent

Employer: _____

Insurance Claim Processing Disclaimer

I authorize the release of medical or other information necessary to process insurance claims. Such information is to be released only for the purpose of filing health insurance claims with insurance companies and related agencies. I authorize payment of medical benefits directly to Lea Lockwood, PhD, LICSW for any services rendered.

Signature: _____ **Date:** _____

Print Name: _____

If signing for minor