CONTACT AND INSURANCE INFORMATION

Patient's Name: _____ **Date of Birth:** _____
Street Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ ( ) cell ( ) home ( ) work messages OK? _
Other Phone numbers: _____ messages OK? _
Email (for scheduling only): _____
Emergency Contact: _____

Insurance Information
Name of Insurance: _____
Insurance ID#: _____ Group #: _____
Insurance Address: _____
_____
Insurance Phone: _____
Subscriber Name: _____ DOB: _____
(if different from patient name)
Subscriber Address: _____
Subscriber Company: _____
Relationship to Subscriber: (circle one) Spouse Child Other

Name of Secondary Insurance: _____
Insurance ID#: _____ Group #: _____
Insurance Address: _____
_____
Insurance Phone: _____
Subscriber Name: _____ DOB: _____
(if different from patient name)
Subscriber Address: _____
Subscriber Company: _____
Relationship to Subscriber: (circle one) Spouse Child Other

PAYMENT AND INSURANCE AUTHORIZATION: I authorize the release of any medical or other information necessary to process claims and obtain authorization for treatment. I give permission to bill my insurance carrier(s) for psychotherapy sessions, and assign all payments for medical services rendered by Dr. Edelson to her.
I understand I am responsible for costs not covered by insurance.

_____ _____
Signature of Patient or Responsible Party Date

COORDINATION OF CARE

Dr. Jill Edelson 4 Hartford Street Newton, MA 02461 (781) 461-6361
Please print and bring this form to your first appointment.

PCP Name: _____
Phone #: _____
Address: _____
Sign if OK to call: _____

Psychiatrist/ Medication Provider: _____
Phone #: _____
Address: _____
Sign if OK to call: _____

Other Psychiatric Provider(s): _____
(Couples or group therapist, for example)
Phone #: _____
Address: _____
Sign if OK to call: _____