Essential Insight Marriage and Family Therapy

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Office: 585-766-8800 Fax: 585-486-3630

Client or Minor Child Information:
First Name: ______________________ **Last Name:** _________________________________
Address: _________________________________ **City:** ___________________ **Zip code:** ______
Hm Phone: ________________ **Work Phone:** ___________ **Cell:** ________________
Age: ______ **Date of Birth:** ____________ **SS#** ________________________
Email address: ______________________________________

Please indicate where you would like to receive calls: home/work/cel

Employer/School:____________________________**Occupation/Grade:** ___________________
Marital Status: ___________________

Spouse/Parent/Significant Other Information (if applicable):
Name: _____________________________ **Date of Birth** ___________ **SS#** _________________
Employer: ___________________ **Occupation:** ____
Address if different from client: ____

Insurance Information:
Primary Insurance Company: ____________________________ **Phone #** __________________
Address: __________________________ **ID#** _________________ **Group #** _________________
Insured's Name: __________________ **Date of Birth:** ___________

Secondary Insurance Company: __________________________ **Phone #** __________________
Address: _________________________ **ID#:** ________________ **Group#:** __________________
Insured's Name: __________________ **Date of Birth:** ___________

Responsible Party Name: ______________________ **Phone Number:** ______________________
Address: ____

What is your reason for seeking therapy: ____
Who referred you: ____________________
Incase of emergency please notify: __________________ **Phone #:** ______________________
Relationship: ______________________________

I authorize all benefits be paid to Michele Toffany, Ed.D. I understand that I am fully responsible for all expenses associated with this therapy. I hereby apply for services and given consent for treatment of myself or my minor child: __________________. A fee of $150.00 will be charge for appointments not cancelled 24 hours in advance. This charge is not covered by insurance and payment is the responsibility of the client or parent. If processing insurance claims, the therapist is authorized to release information.

Signature: _______________________________ **Date:** ___________________________