Essential Insight Marriage and Family Therapy

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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 Tofany, Ed.D. I understand that I am fully responsible for all expenses associated with this therapy and payment of $100.00 for each visit is due at the time of service. 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:** _____