Kera Glazer-Rosoff, Ph. D.

Clinical Psychology

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PATIENT INFORMATION

Patient's Name _____ **Gender** _____ **Age** _____ **Birthdate** _____
Last First M.I.

Racial/Ethnic Background _____

Social Security # _____ **Marital Status** (circle one) Single Married Widowed Divorced

Address _____ **City**_____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email _____
Please check if I may leave a message for you at: Home _____ Cell _____ Work _____ Text _____ Email _____

Referred By _____ **May I thank them for the referral** _____

Family and/or friends to be contacted in an emergency:
Name _____ **Phone** _____
Name _____ **Phone** _____

Employer _____ **Occupation** _____

Employer's Address _____

Responsible Party and/or Spouse Information

Name _____ **Relationship to Client** _____

Birthdate _____ **Social Security #** _____**Occupation** _____

Employer _____ **Employer's Address** _____

Insurance Information

(I do not currently direct bill insurance companies except for Medicare. I will provide a superbill for you to submit for reimbursement)

Please present your insurance card(s)

Primary Insurance _____ **Name of Subscriber** _____

Secondary Insurance _____ **Name of Subscriber** _____

I hereby authorize Kera Glazer-Rosoff, Ph.D. to release any necessary information acquired in the course of treatment to my insurance carrier. This authorization shall remain valid until my written notice is given revoking the authorization. I also authorize direct insurance payments to Kera Glazer–Rosoff. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This signature will also authorize consent to treatment for the above named patient.

Signature _____ **Date** _____