

Michael W. Adamowicz, LICSW, LLC

Patient Information Form

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City/State/Zip: _____

Home Phone: _____ DOB: _____ Soc. Sec. Number: _____

Employer/School: _____ Work Phone #: _____

Primary Ins. Type: _____ Group#: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

DOB (of insured): _____ SSN(of insured): _____

Address (of insured): _____

Employer through which you have this coverage: _____

Second Ins. Type: _____ Group#: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: DOB (of insured): _____

SSN(of insured): _____ Address (of insured): _____

Employer through which you have this coverage: _____

Please list any allergies you have: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____

Michael Adamowicz, LICSW, LLC will bill insurance carriers with whom he has a contract. Your receipt will have all the necessary information needed for reimbursement if you submit claims directly to your insurance company. I authorize payment to Michael Adamowicz, LICSW, LLC for claims submitted on my behalf from my health insurance carrier. I authorize any medical information pertaining to my health to be released to my insurance carrier if necessary in resolving matters relating to benefits, claims and/or authorizations

Patient Signature: _____ Date: _____

I agree to pay all co-payments, deductibles or fees at each visit. I understand that I am responsible for any balance not covered by my insurance company. I understand that I will be charged the FULL FEE for MISSED appointments that are not canceled at least 24 hours in advance. I understand that my health insurance will not reimburse for missed appointments.

Patient Signature: _____ Date: _____