Counseling Services of Cortland

Name_____

Address_____

City_____ State_____ Zip_____

Date of Birth_____

☎ Home Phone_____

☎ Cell Phone_____

☎ Work phone_____

Email address_____

May I leave my name or a message on one of these phone numbers? I am able to text you re: appointments?

YES/ NO

Is it okay to send you something by mail? If so, is it okay if my return address or name appears on the envelope?

Yes / NO

Please indicate preferences that may be helpful for me if you answered "NO" to the above questions.

_____

INSURANCE INFORMATION

(Copayments are due at the time of your office visit. Thank you.)

Insurance Company: _____

(Please provide a copy of your insurance card for billing purposes)

Insurance Policy #: _____

Employer/Provider of

Insurance:_____

(*For example, ABC Corporation)*

I authorize payment of medical benefits. Patient's or Authorized Person's Signature *(Please sign below)*

_____

Medical Information

Your Medical Provider(s):

_____

Medical provider address and phone #:

_____

_____

Please list all medications that you are taking and the provider responsible for the prescription(s):

_____

_____

_____

Do you have any health issues that you are being treated for at this time? Are there any significant medical or mental Health Issues in your family and extended family that you are aware of?

_____
_____
_____
_____
_____
_____
_____

.....

Person to notify in case of an emergency:

Name: _____

Address :_____

Phone: _____

Relationship to you:_____