Jenifer A. Garrido, MSW, LCSW
719 Peachtree Road
Orlando, Florida 32804
407 925-6759

Client Information Form (Adult)

Client Name: _____ **Home Phone:** _____

Address: _____ **City:** _____ **Zip:** _____

Cell Phone/Alt Phone: _____ **Marital Status:** _____

DOB: _____ **SS#:** _____

Employer: _____ **Occupation:** _____

Address: _____ **Work Phone:** _____

May your therapist contact you/leave a message:	**At home**	**Yes**	**No**
***Any messages left for client will only include therapist's name/phone and/or reminder of appt day/time**	**At work**	**Yes**	**No**
	Cell	**Yes**	**No**

Payment Preference: Please choose one - **Self Pay** **Insurance**

Insurance Information: **If more than one policy, please provide information on reverse side of form**
***Leave blank if self pay**
Insurance Company: _____ **Insured:** _____

Insured's relationship to client: _____ **Insured's DOB:** _____ **Insured's SS#:** _____

Address: _____
***Please include PO Box, City, State & Zip**

Phone: _____ **Policy/ID #:** _____

Group #: _____ **Employer:** _____

Release and Assignment (Insurance Clients): I authorize release of any information necessary to process my insurance claims, and assign /request payment to Jenifer A. Garrido, LCSW. I am aware that my insurance company/third party payer may be given information about the type, cost, date and provider of any services that I receive; this will also include diagnostic information. I understand that if payment for the services I have received is not reimbursed by insurance company, I am responsible for payment. (This does not apply to HMO plans the therapist is contracted with and accepts insurance assignment from). I understand that services will be discontinued if payment is not received. By signing below, I agree to the above-stated terms.

Signature: _____ **Date:** _____

Print Name: _____

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 Client Name:_____

Payment Policy (Self Pay Clients): By signing below, I agree to the following terms: I acknowledge that I am responsible for payment at the time that services are rendered. I will be provided with a receipt following each session; I can submit this receipt for reimbursement from my insurance company should I choose to do so. I understand that I am responsible for providing at least 24 hours notice if cancelling an appointment, or I will be charged a $50 fee.

Signature:_____ **Date:**_____

Print Name:_____