Jenifer A. Garrido, MSW, LCSW
719 Peachtree Road, Ste 200
Orlando, Florida 32804
407 925-6759

Client Information Form (Child)

Client Name:______________________________ Home Phone:______________

Address:______________________ City:______________ Zip:__________

DOB:______________

Father: ______________________________ DOB:______________________

Employer:______________________ Occupation:______________________

Address:________________________ Work Phone:____________________

Mother: ______________________________ DOB:______________________

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**	**At work**	**Yes**	**No**
name/phone and/or reminder of appt day/time	**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 Information Form **Page 2** **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:____