Client Data

Patient Name: ____
Address: ____
City: ___________________________ State___ Zip: ___________
Phone: Home_________________ Cell/Msg_________________
E-Mail Address____
Date of Birth: ___/___/______ Social Security #_____-___-_____

Bill to: Self_____ Spouse_____ Parent_____ Other_____
Name:____
Address:____
City: ___________________________ State___ Zip: ___________
Phone: Home_________________ Cell/Msg_________________
Date of Birth: ___/___/______ Social Security #_____-___-_____

Emergency Contact: ______________________________________
Relation: ____
Phone: Home_________________ Cell/Msg_________________

Primary Insurance Name: _________________________________
Phone: _________________
Policy/Claim #____
Group #____________________________
Insured Name: ____________________________________
Auth #/ Pre-Cert # __________________

Secondary Insurance Name: ______________________________
Phone: _________________
Policy/Claim #____
Group #____________________________
Insured Name: ____________________________________
Auth #/ Pre-Cert # __________________

Michael Sibrava, NCC, LMHC
Envision Therapies
(206)473-2435
envisiontherapies@gmail.com

Client Data

Please mark any that apply:

OK to leave voice messages: Yes / No

OK to send emails: Yes / No

OK to send email appointment reminders: Yes / No

OK to send text message (SMS) appointment reminders: Yes / No

I understand that not all forms of communication are secure and that some non-sensitive, but confidential information may disclosed in communication by telephone, email, or text message.
I understand that I can amend my requests limiting or extending methods of contact at any time by resubmitting this form.

Signature______________________________ Date ______________