Discover Healthy Ways to Navigate Stressful Times....

Collins Psychological Therapy & Consulting, Inc.
5190 Governor Dr., Suite 104
San Diego, California 92122
858-536-8985
www.mindfultherapydoc.com

COUPLES CLIENT INFORMATION FORM

PARTNER #1

Name:_____
First Last MI

Street Address:_____

City:_____State:_____Zip:_____

Phone: (H) (____)_____Cell: (____)_____Work: (____)_____
_____

E-mail address_____

DOB____/_____/_____ M / F Driver's License #_____

Employer_____ Title: _____

Primary Care Physician_____Phone: (____)_____

Permission to contact Primary Care Physician to coordinate care? ____Yes _____No

Person to contact in emergency:_____Phone: (____)_____

PARTNER #2

Name:_____
First Last MI

Street Address:_____

City:_____State:_____Zip:_____

Phone: (H) (____)_____Cell: (____)_____Work: (____)_____
_____

E-mail address_____

DOB____/_____/_____ M / F Driver's License #_____

Employer_____ Title: _____

Primary Care Physician_____Phone: (____)_____

Permission to contact Primary Care Physician to coordinate care? ____Yes _____No

Person to contact in emergency:_____Phone: (____)_____

CONJOINT INFORMATION

Marital Status:_____

Referred by:_____Phone:_(____)_____

INFORMED CONSENT:

I consent to assessment and treatment under the care of_____.

By my/our signature (s) below, I/we assume responsibility for all fees incurred. Charges are due and payable at the time of service unless other arrangements have been made to bill the following insurance providers for partial payment of their contracted fee:
_____ Aetna _____ Anthem Blue Cross ____MHN ____ TriWest Choice Program

_____ Cig

If one of the above insurance providers is to be billed I understand that if my insurance provider fails to provide reimbursement that I/we are responsible for payment of the full fee for treatment. I further understand that I/we are responsible for my/our portion or copay of the insurance contracted rate with this provider for payment at the time of service.

I/we am happy to receive quarterly e-newsletters from Dr. Linda Collins announcing workshops and educational information to support your therapy experience. ___Yes ___No

_____

Signature of Partner #1 Date

_____

Signature of Partner #2 Date