HOOD RIVER COUNSELING, PC
704 COLUMBIA ST.
HOOD RIVER, OR 97031

PATIENT INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY: _____

SINGLE: _____ MARRIED: _____ CHILD: _____ OTHER: _____ GENDER: M_____ F_____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

REFERRING PHYSICIAN: _____ PHYSICIAN PHONE: _____

May I notify your physician that you have contacted me? [ ] Yes [ ] No

May I exchange information with your physician for the purpose of coordinating treatment? [ ] Yes [ ] No

INSURANCE INFORMATION NEEDS TO BE FILLED OUT ALONG WITH THE COPY OF YOUR CARDS

PRIMARY INSURANCE

SUBSCRIBER TO POLICY: _____ DOB: _____ SS #: _____

PRIMARY INSURANCE CO: _____

ID #: _____ GRP #: _____ CO-PAY: _____

RELATIONSHIP TO PATIENT: SELF: _____ SPOUSE: _____ CHILD: _____ OTHER: _____

EMPLOYER NAME: _____

INSURANCE PHONE NO: _____

PRE AUTHORIZATION REQUIRED: YES: _____ NO: _____

SECONDARY INSURANCE

SUBSCRIBER TO POLICY: _____ DOB: _____ SS #: _____

SECONDARY INSURANCE: _____

ID #: _____ GRP #: _____ CO-PAY: _____

RELATIONSHIP TO PATIENT: SELF: _____ SPOUSE: _____CHILD: _____ OTHER: _____

EMPLOYER NAME: _____

INSURANCE PHONE NO: _____

PRE AUTHORIZATION REQUIRED: YES: _____ NO: _____

HOOD RIVER COUNSELING, PC and Brian Wolff, LCSW, CADC-III has my permission to bill my insurance(s).
I authorize here to release any information necessary to process my claims.
I further authorize that my insurance benefits be paid directly to HOOD RIVER COUNSELING, PC.

I understand that if I do not cancel appointments at least 24 hours in advance I will pay $50.00 for each missed appointment.

SIGNATURE _____ DATE _____