New Patient Information

lifehelpnow.net
Brenda Fox Dixon
LCSW

Name: First MI Last DOB: Month Day Year

Age: Gender: Social Security Number:

Home Number: ( ) - - Cell Number: ( ) - -

Work Number: ( ) - - Email:

Address: Street City State Zip Code

Emergency Contact: Relationship:

Home Number: ( ) - - Work/Cell Number: ( ) - -

Insurance Information

EAP: Auth. Num. ( ) - - Tele:

Name of Insured: Insured's Employer: DOB: Month Day Year

Social Security Number: Insurance Company: Tricare

Member ID: Group and Plan:

Claims Address: Number: ( ) - -

Deductible: Met:

Copay: Visits per year:

Auth:

Referral Issues/Notes (include MH/SA Hospitalizations last two years)

Brenda Fox Dixon
LCSW

433 Nissan Dr.
Suite 303
Smyrna Tn. 37167

Date: Month Day Year

Client Name: First MI Last

DOB: Month Day Year

Social Security Number:

Referred By:

Address: Street City State Zip Code

Home Number: ( ) -

Work Number: ( ) -

Parent/Gaurdian (minors only):

Phone: ( ) -

EMERGENCY Contact:

Phone: ( ) -

Primary Care Physician:

Phone: ( ) -

Employer:

Occupation:

Primary Insurance: Tricare

Subscriber:

Subscriber DOB: Month Day Year

Please initial: I verify that the above information is correct and I will notify the Therapist of any changes. I am aware that the payment is due the time of the Service or I will make arrangements for payment.

Please initial: I require 48 hour notice of cancellations, otherwise you will be charged for the time reserved for you. Insurance Company will not pay for missed appointments. You will be billed a fee of $35.00. Exceptions for Emergency can be discussed with Therapist. Any additional paperwork requested to be completed by Therapist will have a $35.00 charge.

Please initial: I authorize Brenda Fox Dixon, LCSW to fill a claim with an insurance carrier or EAP to recieve payments directly. I also acknowledge that I am ultimately responsible for full payment of services.

Client Signature: