LICIA GINNE, MARRIAGE & FAMILY THERAPIST, INC.

3201 Wilshire Boulevard, Suite 209 Santa Monica, CA 90403
ph: 310 828-1256 www.LATherapists.com

Couple Information

Date _____

1) Client _____

2) Client _____

☐ Single ☐ Married ☐ Co-habit ☐ Divorced ☐ Separated ☐ Widowed

1) Home address _____

City _____ State _____ Zip _____

Soc.Sec.# _____ Date of Birth _____

Telephone: Home _____ Work _____ Cell _____

Email _____

Preferred contact (check as many as you wish) ☐ Home ☐ Work ☐ Cell ☐ Email

Employer _____ Occupation _____ How long _____

2) Home address _____

City _____ State _____ Zip _____

Soc.Sec.# _____ Date of Birth _____

Telephone: Home _____ Work _____ Cell _____

Email _____

Preferred contact (check as many as you wish) ☐ Home ☐ Work ☐ Cell ☐ Email

Employer _____ Occupation _____ How long _____

Referred by _____

Person to contact in emergency

Name _____

City _____ State _____ Zip _____

Telephone _____

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Insurance Information

Insured Person _____

Soc.Sec.# _____ Date of Birth _____

Insurance Company _____

Insured ID# _____

Policy/Group# _____

Insurance Telephone _____

In signing this agreement my signature acknowledges that I fully agree to and accept the following conditions:

I authorize the release of medical or treatment information necessary to process my insurance claim including the release of a mental or chemical dependency diagnosis.

I accept full responsibility for payment should my insurance carrier not reimburse for services rendered. I understand and accept all financial responsibility for treatment.

1) Client Signature _____ Date _____

2) Client Signature _____ Date _____