Marilee Boe, M.A., L.P.C.

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Centennial, Co. 80111
303-758-2659
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Patient Information

Client Name:____

Date:______________________

Name of Guardian
(if minor)____

Street Address____

City__________________________________State_______ Zip_________________

Primary Phone____________________________ May I leave a message? Y N

work/cell/other____________________________ May I leave a message? Y N

Date of birth: ________________ SSN: ___________________________

Drivers License Number ____________________________ State__________

E-mail____

Emergency Contact:

Name ____

Relationship_____________________

Address ____

Phone______________________________

City__________________________________ State _________ Zip

Insurance Company

Preauthorization Number

Policy Number ________________________ Group Number__________________

Phone Number_________________________

Billing Address:____

Insured's Name____________________________ DOB____________

SSN:_______________ Name of Employer_________________________

<u>Medical Information</u>

Primary Physician ______________________________________

Phone ____________________

Psychiatrist

Phone_____________________

Current Medications

____

____

How did you find me?

Please describe the primary concern(s) you would like to discuss.

What are your primary goals?

What additional information would be helpful for me to know?

<u>* I hereby authorize treatment services and a treatment plan as negotiated. I agree to assume financial responsibility for same. I agree to be knowledgable of my insurance benefits, i using, and the coverage. I agree to pay full fee if my insurance does not cover services. Further, if fees are not received, my account may go to collection.</u>**

________________________________ ____________________

Signature of Responsible Party Date

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Witness