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

marileeboe.com

303-758-2659 fax: 303-773-3844

Client Information

Client Name:_____

Date:_____

Name of Guardian (if minor) _____

Street Address_____

City_____State_____

Zip_____

Primary Phone_____

May I leave a message? work/cell/other_____

May I leave a message? Yes No

Date of birth: _____ SSN: _____

Drivers License Number _____

State_____

Email_____

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_____

Medical Information

Primary Physician _____

Phone _____

Psychiatrist

Phone_____

Current Medications

_____

How did you find me? _____

***** 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.**

_____ _____

Signature of Responsible Party Date