Susan Pauna, M.S., LCPC

Patient Information

Patient Name: _____
First Name Last Name M.I.

How you wish to be addressed: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Work: _____ Cell: _____

Where may we leave a message? ☐ Home ☐ Work ☐ Cell

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Other Marital: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Who referred you to the office? (Name & Phone) _____

Insurance Information

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____
First Name Last Name

Address & Phone: _____

_____

Insurance ID: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____
First Name Last Name

Address & Phone: _____

_____

Insurance ID: _____ Group Number: _____

I hereby authorize Susan Pauna, M.S., LCPC to furnish my insurance company all information which the insurance company may request concerning my present illness. I hereby assign to Susan Pauna, M.S., LCPC all monies to which I am entitled for expenses relative to the services rendered, unless I have out-of-network insurance or no insurance at which time I will self-pay. I understand that I am financially responsible to Susan Pauna, M.S., LCPC Inc for charges not covered by the insurance company.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature (if applicable) Date