Paulette de Coriolis, MA, LMHCA
Mental Health Counselor

Billing Information

Please complete as fully as possible

For Office Use Only
Dx_____
_____
Date of first session
_____

Patient Legal Name_____

Patient Preferred Name_____

Address_____

City_____ State_____ Zip Code_____

Cell Phone (_____)_____ Home Phone (_____)_____

Email Address: _____ May I email you at this address? Y / N

Birthdate____-____-____ Gender:_____ Single ☐ Partnered ☐ Widowed ☐ Separated ☐

Employer_____ Occupation_____

Emergency Contact:_____ Phone:_____

How are they related to you? _____

If another person is responsible for charges

Name_____ Home Phone (_____)_____

Address_____ Cell Phone (_____)_____

Consent for treatment, statement of financial responsibility, and release of information

I hereby give my consent for psychiatric and psychological consultation and treatment.
I understand that each psychiatrist/psychologist in this office is an independent practitioner and no other clinician is involved in the consultation and/or treatment of me or my dependent.
I agree to be financially responsible for all charges that accrue from consultation and treatment.
I agree to be financially responsible for cancelled appointments in accord with my doctor's cancellation policy.
I authorize insurance benefits to be paid directly to the doctor, and that the doctor may release any information to the insurance company required for processing any claims, including information about mental health and substance abuse.
This authorization will remain in effect indefinitely.

Signature of client_____ Date_____
If signed by another responsible person, specify relationship

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