Paulette de Coriolis, MA, LMHC
Mental Health Counselor

Billing Information

Please complete as fully as possible

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 therapist's cancellation policy.
This authorization will remain in effect indefinitely.

Signature of client____ Date________________________

If signed by another responsible person, specify relationship

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