Ann E. Drouilhet, LICSW
40 Speen Street Suite 106
Framingham, MA 01701

NEW PATIENT INFORMATION

Date: ____________

Patient Information:

Name____
First MI Last

Address____________________________________APT#________Cell#__________________

City__________________________ State_____Zip______Telephone # (___)________________

SS#___________________ Sex - M or F Birthdate___________ Marital Status - M; S; D; W

Email:___________________________________

Referred By:____________________________ Medications: ________________________________

Physician: ______________________________ Past Hospitalizations: __________________________

In the event of an emergency please contact:
Name: ________________________ *Phone:* ________________ *Relationship:* ___________

School Information:

School Name ______________________________ Phone # _____________________ Grade ______

Address______________________________City______________ State____ Zip______

Employment Information:
Employment: - F - P/T - Retired - Not Employed - ***(circle one)***
Employer____________________________ Phone (_____)______-____________
Address______________________________City______________ State____ Zip______

Family Members:
Name DOB Address & Phone (home & work)
1
____________________ _____________ ____

2
____________________ _____________ ____

3

4		
5		
6		

Please be sure to turn over the form and complete *the other side. Thank you* !

Client Name____

Insurance Plan Name____

Address________________________City_________State Phone ___________________

Subscriber Name____________________________________("Same" if same as patient)

Subscriber Address___________________________________("Same" if same as patient)

Relationship to Patient____________________Subscriber DOB_____________________

Subscriber ID#__________________Group#________________Policy#______________________

Guarantor____________________________ Precertification #___________________Co-Pay.________

Diagnosis code: _______________________

PATIENT or AUTHORIZED PERSON'S SIGNATURE REQUIREMENTS

Release of Information

I (patient, parent or guardian) authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed___________________________ Date_____________________
(Patient/authorized person)

Assignment of Benefits

I authorize payment of medical benefits to Ann Drouilhet, LICSW:

Signed___________________________ Date_____________________
(Patient/authorized person)

Confidentiality/Privacy Policies

I have received and understand my rights to protect my privacy and the confidentiality of services provided

Signed___________________________ Date_____________________
(Patient/authorized person)

Cancellation Policy

I request that you give me at least 24 hours notice if you must cancel an appointment. If you must cancel on short notice for unavoidable reasons, please call to let me know that you are not coming. I charge my usual fee for unnecessary cancellations or missed appointments. Please be aware that insurance companies will not pay for canceled or missed appointments.
I have read and understand the cancellation policy.

Signed___________________________ Date_____________________
(Patient/authorized person)