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Client Information Sheet

Family Name _____ Date _____
Address _____ Phone (h) _____
City _____ State _____ Zip _____ Phone (w) _____
Client # 1 _____ Date of Birth _____
Client # 2 _____ Date of Birth _____
Client # 3 _____ Date of Birth _____
Referred by _____ Phone _____
Reason for referral: _____
Email address: _____

Insurance Information

Name of insurance company _____
Insurance ID # _____ Group # _____
Subscriber's Name _____ Employer _____
Annual Out-patient mental health benefit _____ Am't used this year to date _____
Deductible _____ Co-payment per session _____
Pre-certification done? _____ Authorization # _____ Sessions granted? _____
Insurance Company contact phone # (mental health benefits) _____
Insurance Company claims mailing address: _____

Authorization to provide services & responsibility for fees: I understand that I am responsible for all fees. If I am requesting that you access my health insurance benefits: I accept responsibility for all fees not directly paid by my health insurance; I accept responsibility for contacting my insurance company and meeting all of their requirements; and, I authorize release of information, including behavioral health questionnaire responses, to my insurance company. I understand that should I (or either of us) call you to appear before any legal proceeding, I will be responsible for personally paying fees charged for your time.

Name

Name

Signed

Signed

Notice of Privacy & Confidentiality Policies received:

Initials

Initials