Chuck Stannard, MSW 2014 Delta Blvd. Tallahassee, FL 32303
Licensed Clinical Social Worker #3031 Licensed Marriage & Family Therapist #1156

Insurance Information and signed consents for treatment

Name____

Address_________________________ City ______________ State _________

Zip code__________ Home phone______________ Work phone ____________

Cell phone _________________ Date of birth ___________SSN____________

Primary insured person's name ____________________________________

Insured's ID # ______________________________ Policy/ group # __________

Insurance company ____

Address of company (if **other** than TBHP, CHP, BCBS) ________________________

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Phone # and or contact for insurance company ______________________________

Name of your primary care physician ______________________________

If there is secondary insurance coverage who is it with? __________________________

Please assign directly to Chuck Stannard, MSW all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the therapist to release all information necessary to secure payment for benefits.

signature ________________________________date ________________

I give consent for Chuck Stannard,MSW to provide psychotherapy services to myself, or to my son or daughter if they are the referred or identified client. My signature also affirms that I have read and agree to the information included in the orientation to services handout.

signature ________________________________ date ________________

I have reviewed the **Notice of Privacy Practices** and realize a copy will be provided for me upon request.I also understand that failure to sign this will not effect the availability of my services to you.

signature ________________________________ date ________________

Who referred you to this office? ____________________________________

Have you had any previous counseling? ________. If yes , would you be willing to sign a release form for me to receive this information? ___yes ___no

Is there anything in particular that you would like me to know from the outset? (Reason for referral here, diagnosis, meds) ____________________________________

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