James Reavis, LCSW
1012 SW King #304
Portland, OR 97205 Phone: 503.880.7912

Client Information

NAME _____ DATE _____

ADDRESS _____
(street)

_____
(city) (state) (zip)

PHONE (Mobile) _____ (Home) _____ (Work) _____

Partner Name _____ Partner Mobile _____

REFERRED BY _____PHONE _____

EMPLOYER _____ OCCUPATION _____

DATE OF BIRTH _____AGE _____ GENDER _____M _____ F

EMERGENCY CONTACT (name) _____ (phone) _____

****

Health Insurance

(Copy of insurance card is made at first appointment)

COMPANY _____

ADDRESS _____

PHONE _____ PREAUTHORIZATION NEEDED _____

NAME OF INSURED_____

ID # _____ DEDUCTIBLE _____ COPAY_____

DEDUCTIBLE MET _____ YES _____ NO

I authorize the release of any medical information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____

Signature Date