Cheryl L. Stolz, Ph.D. **Client Information Sheet**

Client Information (Please Print)

Name_____ Age _____ Birth Date ____/____/____

Address _____ Marital Status: _____ Sex: M F T GNC

City _____ State ____ Zip _____ Home Phone (____)_____

Employer _____ Occupation _____ Work Phone (____)_____

Who referred you to the office? _____ Cell Phone (____)_____

Family or Primary Care Physician _____ E-mail _____

Responsible Party (If same as client, please skip to next section)

Name _____ Date of Birth ____/____/____ Sex: M F T GNC

Address _____ Phone (____)_____

Insurance Information

Primary Insurance_____

Group No._____

Subscriber No._____

If work related, claim # _____

Ins. Co. Phone No (____)_____

Secondary Insurance_____

Group No._____

Subscriber No._____

Policyholder name _____

Ins. Co. Phone No (____)_____

Emergency Contact (not residing with you)

Name _____ Home Phone (____)_____

Address_____ Work Phone (____)_____

Relationship to patient _____

Assignment of Insurance Benefits

I hereby assign payment of authorized benefits to which I am entitled to be made directly to Dr. Stolz for services she provides to me. I authorize any holder of medical information about me to release any information needed to determine if these benefits are payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges not made by insurance. I hereby authorize Dr. Stolz to release all information necessary to secure payment.

Signature:_____ Date:_____