# *Jerome Mills, LCSW*

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**Lafayette, LA 70503**
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**PLEASE HAVE PATIENT COMPLETE THE FOLLOWING**

## Patient Information:

Patient Name: ________________________________________

Address: ________________________________________

________________________________________

Phone: ________________________________________

Date of Birth: __/__/____ Sex:__Male __Female

Relationship to Insured Person:__Self__Spouse__Child__Other

Marital Status: ___S ___M ___W ___D ___Separated

Employed:__Yes __No Student:__Full-time__Part-time

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## Insured Information:

Insured **Person** Name:________________________________

Address: ________________________________________

________________________________________

Phone: ________________________________________

Insurance Co: ________________________________________

Insurance Co Phone #:________________________________

Date of Birth: __/__/____ Sex: __Male __Female

Social Security #: ________ - ______ - ________

Employer Name: ________________________________

Employer Phone: ________________________________

Policy/Group #: ____________________________

ID#: ________________________________________

**AUTHORIZATION TO RELEASE INFORMATION – ASSIGNMENT OF INSURANCE BENEFITS**

I authorize the release of any medical or other information necessary to process insurance claims and payment of medical benefits to the above provider for services provided.

**Signature of Patient (parent if a minor)_X________________________________ Date:____________________**

## **Please Have Insurance Card Available for Copying**

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**FOR OFFICE USE ONLY**

Diagnosis Code: ______________________________

Diagnosis Desc: ________________________________________________________________

| DATE | CPT CODE | CHARGE | CO-PAY | BALANCE | AUTHORIZATION NUMBER |
|---|---|---|---|---|---|
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| | | | | | |