LINDA EVANS, PH.D.
TOWN CENTER, 116 W. 7TH, SUITE 211
STILLWATER, OK 74074
405-707-9600

NAME_____AGE_____DOB_____
ADDRESS_____
HOME PHONE_____WORK PHONE_____
CELL PHONE_____SS#_____
EMAIL (where we can send information about appointments or information regarding counseling) _____
EMPLOYER_____ADDRESS_____
INSURANCE CO._____
POLICY#_____GROUP#_____
INSURANCE CO. ADDRESS_____
ID#_____PERSON INSURED_____
INSURANCE CO. PHONE NUMBERS _____
SUPPLEMENTAL INSURANCE?_____POLICY # & COMPANY_____
_____

I give my permission to release to the following person(s), dates of service, charges, diagnostic impressions, agreement to pay form, and any other information necessary to bill and receive payment for services:
Name of responsible party: _____
Address of responsible party: _____
_____

_____
Client Signature

In case of emergency any kind of, you may contact the following people:

NAME_____ADDRESS_____
RELATIONSHIP_____PHONE(Hm)_____
PHONE (Wk) _____PHONE (Cell)_____

NAME_____ADDRESS_____
RELATIONSHIP_____PHONE(Hm)_____
PHONE (Wk) _____PHONE (Cell)_____

_____
Client

You may send emails to the email address listed above.

_____
Client

_____
Witness

_____
Date
2016Rev