Cynthia R. Pratt, M.A., L.P.

Initial Contact Date:

Name: _____ DOB_____
Address:_____
_____
Home phone:_____ Work Phone_____
Cell Phone_____ SS#_____
OK to leave message? Y___ N____ Y_____ N_____

Reason for seeking
counseling:_____
_____
_____

Referred
by:_____

Insurance Information:

Primary Insurance:_____ Phone:_____
Address:_____
_____
Insured's Name_____ Date of Birth_____
ID Number:_____ Group Number_____
Deductable:_____ How much has been met?_____
Renewed when?_____ % paid by insurance?_____
Copay_____ Prior needed? After which session?_____

Secondary Insurance:
Name:_____Phone:_____
Address:_____
_____
ID#_____ Group#_____