

Linda Esposito, LCSW

www.southpasadenatherapist.net

(626) 710-6578

Client Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip code: _____

Mobile Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ City: _____ Zip code: _____

Mobile Phone: _____ Work Phone: _____

Referred by: _____

***Subscriber Insurance Information (Required for "Superbill"): *N/A for co-parenting services**

Name _____ Birthdate _____

Address _____

Phone Number for Ins. Co. _____

Insurance Type _____

Policy Number _____

Group Number _____

*I authorize the release of information necessary to process health benefit claims for myself and/or family member. I understand there is a possibility that I may not be eligible for reimbursement for a portion, or any of the psychotherapy services rendered, according to my PPO health insurance plan.

Signed _____

Date _____