RICHMOND THERAPY CENTER

HENRY E. MORRIS, Ph.D.
Licensed Clinical Social Worker
2008 Bremo Road, Suite 103
Richmond, Virginia 23226

DX _______________

Entered ____________

PATIENT INFORMATION

Name ____ Date ____________________

Address ____________________________________ City/State ______________________ Zip _______________

Home Phone ____________________ Birth date _______________Age _______________ Sex ____F ____M

Cell Phone _______________ Business Phone _________________ Employer ____________________________

Occupation ____ Social Security Number _______________________

Person Responsible for Payment *(if other than patient)* ____

Address ____________________________________ City/State ______________________ Zip _______________

Social Security Number _______________________ Relationship to Patient ____________________________

In an Emergency Notify Phone ____

If Insurance may cover part of these costs, please give the following information:

____

Insurance Company Subscriber Subscriber's Date of Birth Subscriber ID#

____

Phone Claims Address Group #

Does your **mental health insurance** coverage require pre-authorization? ________________________________

If yes, have you obtained this? ___________ Authorization # ____

Number of visits authorized: _____________

____

Secondary Insurance Company Subscriber/Policy Holder Subscriber ID#

____

Phone Claims Address Group #

Does this insurance company require pre-authorization? _________

If yes, have you obtained this? ___________ Authorization # ____

Number of visits authorized: _____________