Willow Tree
THERAPY CENTER

Patient Information

First Name: _____ MI: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Birth Sex: _____ Gender Identity: _____

Marital Status: _____ Social Security #: _____ Phone*: _____

Who referred you to us: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Email for appointment reminders* (optional): _____

*By providing my email address/phone number, I consent to have my clinician communicate with me via email/phone regarding appointment reminders and scheduling. I understand that email is not a confidential method of communication and that there is a risk that email may be intercepted by third parties or transmitted to unintended parties.

Primary Insurance Company: _____

Insured's Name: _____

Insured's Address and Telephone (if different): _____

_____

Insured's SS#: _____ Date of Birth: _____

ID#: _____ Group #: _____

Please let us know if you have secondary insurance and we will provide you with an additional form.

I hereby authorize my clinician to furnish my insurance company with all information that the insurance company may request concerning my present illness. I hereby assign to my clinician all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to my clinician for charges not covered by this assignment.

_____ _____

Signature of Patient or Legal Guardian Date

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