Skylight Counseling, LLC Services Application—Therapist: Heather Severn Callister, LMFT

First Name	Middle	Last			Today's Date
Street Address			City	State	Zip
DOB	Age	Sex	Email Address		Phone Cell
List current or previous health problems			Medications		Employer Name

[ ] Spouse/Partner Information or [ ] Parent Information if client is under 18

First Name	Middle	Last			Marriage Date
Street Address			City	State	Zip
DOB	Age	Sex	Email Address (optional)		Phone Cell
List current or previous health problems			Medications		Employer Name

Please list children

Name	**DOB**	**Lives with you?**	**Name**	**DOB**	**Lives with you?**

Payment arrangement: Self-pay____ Insurance Pay____ 3rd Party ____

Responsible party or insured person's name		**Primary Insurance Company**	
Name	DOB	Name	Phone
Phone		Street Address	
Street Address		City, State, Zip	
City, State, Zip		Policy #	
Employer		Group #	
Business Phone		Co-pay Amount	

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO INSURANCE OR THIRD PARTY

I/we authorize Heather Severn Callister or the Billing Manager or the Accountant, to disclose PHI to the above listed insurance company or third-party payer for the purpose of receiving payment reimbursement directly to Skylight Counseling, LLC.

Signature(s) _____ **Date:** _____