ANA I. AGUIRRE-DEANDREIS, Ph.D. **Clinical Psychologist**
6325 Executive Boulevard, Rockville, Maryland 20852 Tel:(301)571-2324 Fax:(301)770-0276

CLIENT INFORMATION FORM

Name of Client _____ Date of Birth_____ Age_____

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____ SSN_____

Occupation_____ Marital Status _____ Employer_____

Referred By_____

Please note that I do not accept insurances and payment is due at the time of visit. However, I can provide you with a printed claim form if you so wish that you may submit directly to your insurance for reimbursement. If you would like a claim form, please fill out the information below:

Health Insurance information:

Name of Policy Holder:_____ Policy Holder's DOB:_____

Name and Address of Insurance Co. _____

Name of Policy Holder'sEmployer:_____

Policy ID#:_____ Group #:_____

Patient Relationship to Insured: Self_____ Spouse_____ Child_____ Other _____

FOR CHILD AND ADOLESCENT CLIENTS ONLY:

School_____ Grade_____ Parent's Marital Status _____

Parent 1: Name and Address_____

Parent 1: Home Phone _____Work Phone_____ Cell Phone_____

Parent 2: Name and Address_____

Parent 2: Home Phone_____ Work Phone_____ Cell Phone_____

AUTHORIZATION FOR TREATMENT:

I have read Dr. Aguirre-Deandreis' informed consent and accept the terms as stated. I accept financial responsibility for services rendered and understand that diagnostic information in the form of a diagnostic code is included on claim forms or statements.

_____ _____

Signature Date