

# Judith Mazza, Ph.D., PA

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Licensed Psychologist

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## Client Information

Please complete the following form, fill it out at your own convenience, and fax it, or bring it with you. The completed form will not email properly

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
Patient's Employer \_\_\_\_\_ Occupation/Student \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Financially Responsible Party:

Responsible Party's Name \_\_\_\_\_  
Relation to Patient  Self  Parent  Spouse  Other  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Business Phone # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

Name of Insured \_\_\_\_\_  Check here if home address and phone number of the insured's are the same as the patient's

Relation to Patient  Self  Parent  Spouse

Insured's Date of Birth: \_\_\_\_\_

Insured's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Address \_\_\_\_\_  
\_\_\_\_\_

Patient's Name \_\_\_\_\_

## Insurance Information

Payment is due at the time of service by either check or cash. We do not accept credit cards at this time. We are pleased to prepare insurance forms for you to submit directly to your insurance carrier. The completed insurance form will be mailed to you after the first session and a completed form will be given to you at each session thereafter. Please check with your insurance carrier directly to understand your out of pocket expenses. As Dr. Mazza is a non-participating provider, you must have out-of-network benefits to receive any reimbursement from you insurance carrier.

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Other Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is this a Worker's Compensation Case?  Yes  No Date of Injury: \_\_\_\_\_

Claim # \_\_\_\_\_

Worker's Compensation Insurance

Carrier \_\_\_\_\_

Is this an Auto Accident Case?  Yes  No Date of Accident \_\_\_\_\_

Name of Attorney \_\_\_\_\_

Referred By \_\_\_\_\_ Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature: \_\_\_\_\_