Judith Mazza, Ph.D., PA
7112 Armat Drive Bethesda, Maryland 20817-2106
Licensed Psychologist

Telephone: 301-365-0922 E-mail: jmazza@familytherapy.com
Telephone: 301-469-7200 Website: www.familytherapy.com

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 _____

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: _____