Summary Page

Client's Name: _____ Sex: _____ Date of Birth: _____ Age: _____

Client's Status: Single Married Divorced Widowed Employed Full-Time Student
Other _____

Parent (If Client is Underage)/Spouse: _____

Address: _____ City/State/Zip: _____

Grade: _____ Children/Siblings: _____

Phone: _____ Phone: _____

E-mail: _____

Referred to Kerry DeVries by: Pastor/Church Friend Doctor School
Internet _____ Other _____

Therapist: _____ First Session Date: _____

Insurance Information:

Policy Holder: _____ Ins. Company: _____ ID#: _____

Group #: _____ Policy Holder's Date of Birth: _____ Sex: _____

Client's Relationship to Policy Holder: _____

Insurance Claim Mailing Address: _____

City/State/Zip: _____

Is There a Secondary Insurance Plan? YES NO

If So, What is the Secondary Insurance Policy Information?

Policy Holder: _____ Insurance Company: _____

Policy Holder's ID#: _____ Group #: _____

Policy Holder's Birthdate: _____ Sex: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myslef or to the party who accepts assigmnment.
Signed:_____
Date:_____

I authorize payment of medical benefits to the provider for the services rendered.
Signed:_____
Date:_____

Notes: