# *Intake Form for Estee Diamond, MS, LMFT*
## *Tel. 818.380.1521*

**TODAY'S DATE:** Private Pay / Insurance:

Your Name: Age: Date of birth:
Adress:
City:
State:
Zip:
Home Phone: Cell: Email Address:

Partner Name: Age: Date of birth:
Address (if different from above):
City:
State:
Zip:
Home Phone: Cell: Email Address:

Names and ages of children if applicable:
Profession:

Name and number of person to contact in case of an emergency:

**INSURANCE INFORMATION**
ASSIGNMENT AUTHORIZATION & RELEASE: I hereby authorize the release of any medical or other information to my insurance company necessary to process this claim. In the event of a claim made to an insurance company seeking reimbursement of charges referred to herein, I agree to assume responsibility for collection of those charges from the insurance company.

Policy Holder:
Policy Holder's Date of Birth:

SIGNATURE OF POLICY HOLDER: X__________________________________________DATE: _________

Insurance Company:
Insurance Co. Address:
Insurance Co. Telephone Number:
Subscriber ID:
Group #/ Group Name:

I hereby authorize payment of medical or other benefits to provider of service(s) identified herein.

SIGNATURE OF POLICY HOLDER: X__________________________________________DATE: ______________________

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:** I hereby authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable upon presentation of a statement of those charges, unless credit arrangements are agreed upon in writing. I agree that all charges shown on those statements shall be deemed to be correct and responsible, unless I make written protest of the charges within thirty days of the billing date. I agree that the charges will be subject to a late charge of 1.5% per month on the unpaid balance. ATTORNEY FEES: It is agreed that in the event that legal action is necessary to enforce the terms of this agreement, the prevailing party shall be entitled to reasonable attorney's fees in addition to any other relief to which he/she might be entitled.

SIGNATURE OF RESPONSIBLE PERSON: X_____________________________________DATE:_______________

Who may I thank for this referral?