Kathryn Miller, LCSW, BCD
Certified Anger Therapist

The Conference Center
22 Parman Place, San Antonio, TX 78230
www.kathrynmillertherapy.com

PATIENT INFORMATION FORM

Date:	

Name:		Email:			
Mobile:		Home:			
Address:		Work:			
City:		State:		Zip:	

Age:		DOB:		Gender:		Marital Status:	

RESPONSIBLE PARTY

Name:		Email:			
Mobile:		Home:			
Address:		Work:			
City:		State:		Zip:	

Relationship to Patient:	

INSURANCE INFORMATION

Insurance Company:		Phone:	
Subscriber's Name:		SSN:	
Employer:		DOB:	
Member #:		Group #:	

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made in writing and agreed upon by the provider.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.

AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

Signature:		Date:	