Lorry G May, LISW-CP

Telephone 864-561-9053 | lorrygmalisw@gmail.com

Patient Information:

Patient's Full Name: ____
(Last Name) (First Name) (Middle Initial)

Patient Social Security Number:_______________________

Street Address:____

City:______________________ State:______________ Zip Code:______________

Phone Number:____________________ Email:______________________

Date of Birth:________________ Gender:________ Marital Status:________________

Patient Employer/School: ______________________________________

City:______________________ State:______________ Zip Code:______________

Emergency Contact Information:

Emergency Contact: ________________________ Relationship to Patient: ______________

Emergency Contact Phone: ____________________

Primary Insurance Information:

Insurance Company Name: __________________________ Effective Date: __________

Insurance Company Phone: ______________________

Insurance Claim Mailing Address (Street Address):______________________________

City:______________________ State:______________ Zip Code:______________

Member ID #:______________________ Group#: ________________________

Insured/Subscriber Name (as it appears on card):______________________________

Relationship to Client: ______________________ Subscriber Date of Birth: ______________

Subscriber's Address (Street Address): ______________________________________

City:______________________ State:______________ Zip Code:______________

Subscriber's Social Security Number: ______________________________________

Subscriber's Employer: ____

Secondary Insurance Information (if applicable):

Insurance Company Name: __________________________ Effective Date: __________

Insurance Company Phone: ______________________

Insurance Claim Mailing Address (Street Address):______________________________

City:______________________ State:______________ Zip Code:______________

Member ID #:______________________ Group#: ________________________

Insured/Subscriber Name (as it appears on card):______________________________

Relationship to Client: ______________________ Subscriber Date of Birth: ______________

Subscriber's Address (Street Address): ______________________________________

City:______________________ State:______________ Zip Code:______________

Subscriber's Social Security Number: ______________________________________

Subscriber's Employer: ____

It is very important that you provide us with complete, accurate and current insurance coverage. **We must have a copy of all insurance cards.**

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Guarantor Information:

(Guarantor is the person responsible for the balance of fees after insurance pays on the account (if applicable). If you are 18 or older you are your own Guarantor. If the patient is under 18, the Guarantor is the patient's legal guardian.)

Guarantor Social Security Number: ______________________________ Guarantor Phone Number: __________________
Street Address: ____
City:____________________________________ State:______________________ Zip Code:_________________________
Phone Number:____ Email:____
Guarantor Employer: ____ Guarantor Employer Phone Number: ___________

Primary Care Physician Information:

Physician Name: ____
Street Address: ____
City:____________________________________ State:______________________ Zip Code:__________________________
Phone Number:____

Referral Information:

Referred by: ____

Authorization: I authorize my mental health practitioner to release information about me to my insurance company and the professional who referred me. This information is protected under the Privacy Act, the Drug Abuse Office and Treatment Act, and the Comprehensive Alcohol and Alcohol Prevention Treatment and Rehabilitation Act. I hereby assign all medical benefits, including major benefits including MEDICARE, PRIVATE INSURANCE and other health plans to Lorry G May, LISW-CP, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. **I understand that I am financially responsible for all fees incurred, even in the instance my insurance company denies the claim.** I hereby authorize said assignee to release all information necessary to secure payment. I understand that payment is due at the time of service at each visit.

Patient/Guardian Signature: ____ Date: __________________________