Elizabeth L. Anderson, Psy.D.
Licensed Clinical Psychologist
Life Transformation Psychological Center, P.C. **www.drelizabethanderson.com**
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Lawrenceville, GA 30043 **770.674.8257**

CLIENT INFORMATION

Date:_____ Referred By:_____

Name:_____ Preferred Name:_____
(Last) (First) (Middle Initial)

Address:_____
(P.O. Box or Street) (City) (State) (Zip)

Telephone:_____
(Home) OK to leave message? Yes___ No___ (Cell) OK to leave message? Yes___ No___

Email (Optional):_____ Date of Birth:_____ Age:_____

Sex: M_____ F_____ Marital Status: _____ Social Security #:_____

Employer or School Name:_____ Position:_____

Education:_____ Religion:_____

Do you want your Religion/Spirituality incorporated in treatment? Yes_____ No_____

Residential Situation:_____Race:_____
(i.e. living w/ parents, alone, single-family home, apartment, etc.)

Emergency Contact:_____ Telephone:_____ Relationship:_____

Insurance Coverage: Yes_____ No_____ Insurance Co:_____

Insurance Plan Name:_____ Insurance Telephone:_____

Insurance Group #:_____ Insured's ID #:_____

Primary Coverage's Name/Address:_____
(If covered under spouse/parent's insurance)

DOB of Insured:_____ Social Security # of Insured:_____

Employer of Insured:_____

If Patient is a Minor:
Mother:_____ Phone:_____

Address:_____

Father:_____ Phone:_____

Address:_____

Guardian:_____ Phone:_____

Address:_____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I request payment of the government benefits either to myself or to the party who accepts assignment below. I also permit a copy of authorization to be used in place of the original.

Signature:_____ Date:_____
(Patient, Parent, or Legal Guardian)

I request the payment from my insurance company be made directly to Elizabeth L. Anderson, Psy.D. with Life Transformation Psychological Center, P.C.
I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature:_____ Date:_____
(Patient, Parent, or Legal Guardian)