TERRY A. RIFKIN L.C.S.W.

THERAPY FOR INDIVIDUALS, COUPLES & FAMILIES

Patient Name: ________________________ Date of Birth: ____________

Parents or Guardian (if under 18): ________________________

Social Security #: ________________________

Home Address: ________________________

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Telephone: Home: ____________ Work: ____________ Mobile: ____________

Email: ________________________

Insurance Company: ________________________

Member I.D.#: ________________________ Group#: ____________

Address: ________________________

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Closest Relative Not Living With You: ________________________

Telephone of Relative: ________________________

I have read and agree to the Patient Policy Statement:

Signature: ________________________ Date: ____________

I authorize payment of benefits to Terry A. Rifkin for services rendered:

Signature: ________________________ Date: ____________

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