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: _____

_____

Telephone: Home: _____ Work: _____ Mobile: _____

Email: _____

Insurance Company: _____

Member I.D.#: _____ Group#: _____

Address: _____

_____

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: _____

30011 Ivy Glenn Drive, Suite #206
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