



Client Information

Name _____ Soc. Sec. _____
Last Name, First, Middle Initial
Address: _____
City _____ State _____ Zip code _____
Home Phone: _____ Cell Phone: _____
Birthdate _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___
Client Employed by _____ Occupation _____
Business Address _____ Business Phone _____

Primary Insurance

Name of Insured _____
Last, First, Middle Initial
Relation to client _____ Birthdate _____ Soc. _____
Address (if different from clients) _____ (Phone if different) _____
City _____ State _____ Zip code _____
Insured Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber ID _____

Additional Insurance

Are you covered by additional insurance? Yes ___ No ___
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different) _____ (Phone if different) _____
City _____ State _____ Zip Code _____
Subscriber Employed by _____ Occupation _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber ID # _____

Assignment and Release

I authorize payment of medical or government benefits directly to Manuel Gomes, MHR, MA for providing treatment. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize this mental health practitioner, or insurance company to release any information necessary to process this claim.

Client's Signature _____

I authorize Manuel Gomes to share with Office Ally billing services only that information regarding psychotherapy which is necessary to obtain payment from my insurance company.

Client's Signature _____