Anxiety Treatment Center of Orlando
Jenifer A. Garrido, LCSW
719 Peachtree Road, Ste 200
Orlando, FL 32804
407-925-6759

Adult Information Form

Client Name:_____ DOB:_____

Home Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Occupation:_____

Work Address: _____Work Phone: has _____

_____

Insurance Information: If more than one policy, please provide information on reverse side of form
*Leave blank if self pay
Name of Insurance
Company: _____

Address: *Please include PO Box, City, State & Zip
_____Phone:_____

ID:_____Group:_____

Name of Primary Insured:_____DOB:_____

Home Address:_____Phone:_____

Relationship to Client:_____Employer:_____

May your Therapist leave you a voice message-

At home: Y or N

On your cell: Y or N

Via Email Y or N

Confirm appointments via text: Y or N

Release and Assignment (Insurance Clients): By signing below, I agree to the following terms:

- [ ]I acknowledge that Jenifer A. Garrido, LCSW, is a private-pay practitioner, is not an in-network provider for any insurance companies, thus, I am responsible for payment in full, at the time that services are rendered. I will be provided with a receipt following each session; I can submit this receipt for reimbursement from my insurance company should I choose to do so;
- [ ]While Jenifer understands that emergencies do occur, failure to provide her with at least 24 hours notice that I will be unable to attend an appointment, will result in my responsible for a $50 fee. I also acknowledge that recurrent cancellations or failure to pay for services will result in discontinuation of services.

- [ ] Applies only to individuals with unlimited coverage or a SCA Should it be necessary, I authorize release of any information required to interact with, assist with reimbursement or process any insurance claims, and/or assign /request payment to Jenifer A. Garrido, LCSW. I am aware that my insurance company/third party payer may be given information about the type, cost, date and provider of any services that I receive; this will also include diagnostic information.

Signature:_____ Date:_____

Printed Name of Client:_____