Psychotherapy Services of CT, L.L.C.
Vernon, CT 06066
Phone: (860) 647-8995
Fax: (860) 647-6930

Patient Information

Name _____ Date of Birth _____/_____/_____ SS # _____

Parent/Guardian (*if applicable*) _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

E-Mail Address _____

Can we communicate to you by: E-Mail ____ Yes ____ No **or** Texting ____ Yes ____ No

Marital Status: Single ____ Married ____ Other _____ Full Time Student: Yes _____ No _____

Employer _____ Occupation _____

Relationship to Insured: Self __ Spouse __ Child __ Other __ If other, please explain _____

Insurance Information - Primary

Policy Holder Name _____ Date of Birth ____/_____/___ SS #_____

Address _____ City _____ State _____ Zip _____
If different from above

Insurance Company _____ Member/Subscriber ID _____

Phone Number for Mental Health Services (*on back of card*) _____

Insured's Employer _____ City _____ State _____ Zip _____
If different from above

Insurance Information - Secondary

Policy Holder Name _____ Date of Birth _____/_____/_____ SS # _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Member/Subscriber ID _____

Phone Number for Mental Health Services (*on back of card*) _____

Insured's Employer _____ City _____ State _____ Zip _____
If different from above

I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignment.
I am also responsible for payment of non-covered services.

Signature _____ Date _____

Revised: 1/2/09