Susan Sabol, Psy.D. 2843 South County Trail, East Greenwich, RI. 02818 401-884-9895

Client Information

Client's Last Name _____ First Name/MI _____ Date _____

Address _____City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work/Ext _____

Date of Birth _____ Referred by _____

Marital Status: Married ___ Single ___ Widowed ___ Divorced ___Separated ____ Partnered _____

Employer Name/Address _____

Occupation _____ Full-time _____ Part-time _____

Attending School: Full-time ___ Part-time ___ N/A ___ School _____

Emergency Contact _____ Relp _____

Address _____

Emergency Contact Phone #s _____

Medical Insurance Information

Primary Ins _____ Secondary Ins _____

ID # _____ Group # _____ ID # _____ Group # _____

Ins.Phone # _____ Ins Phone # _____

Subscriber's Name _____ Subscriber's Name _____

Date of Birth _____ Date of Birth _____

Relationship: Self ___ Spouse ___ Other ___ Relationship: Self ___ Spouse ___ Other _____

Subscriber's Employer _____ Subscriber's Employer _____

Name of Primary Care Physician _____ Phone # _____

Insurance Authorization and Assignment

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to Susan Sabol, Psy.D., for myself and/or dependents. I understand that I am responsible for any deductibles, co-insurances, or amounts for services not covered by the insurance carrier, including **full session charges for missed appointments and those cancelled less than 24 hours in advance.** This authority shall remain in full effect until withdrawn in writing by the undersigned.

I also authorize Susan Sabol, Psy.D., to release any medical/mental health information that may be necessary for either medical care or in processing applications for financial benefit. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original. I am aware and do consent and authorize Susan Sabol, Psy.D., to disclose information pertaining to my identity, diagnoses, and treatment to the Utilization Manager and/or any authorized Utilization Review/Managed Care Company or subcontractor employed by my insurance company. This information needs to be disclosed for the purpose of obtaining health insurance payments for charges incurred by the client as a result of treatment by Susan Sabol, Psy.D.

I am aware that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45CFR, Parts 160 and 164), Federal regulation 42 CFR, Part 2 (Confidentiality of Alcohol and Drug Abuse Treatment), and the General Laws of the State of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided for by law. I understand that, by law, I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above.

Signature _____ Date _____

Print Name _____

Relationship to Client: Self_____ Parent_____ Guardian_____