Valerie Correa, MA, LMFT, Psy.D.
802D Officer's Row
Vancouver, Washington 98661

New Patient Form

Personal Information: Date: _____

Patient Name (First, Middle Initial, Last) _____

Address: _____

City: _____ State: _____ Zip: _____

Parents Names (if patient is a child) _____

How would you like the name on your statement to read: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Is it okay to leave a message at one of the above numbers? _____

Email: _____

SSN: _____ Referred By: _____

Sex: (Please Circle) M F Marital Status: _____

Employment / Student Status: _____ DOB: _____

Primary Insurance Co: _____

Policyholder Name (if different than clients): _____ DOB: _____

Insurance phone number for mental health benefits: _____

Insurance Identification#: _____ Group Identification#: _____

Secondary Insurance Co: _____

Policyholder Name (if different than clients): _____ DOB: _____

Insurance phone number for mental health benefits: _____

Insurance Identification#: _____ Group Identification#: _____

Dr. Valerie Correa has my permission to communicate with my insurance company and to provide information necessary for the purposes of obtaining authorization for services, provision of services and coordination of care. Dr. Valerie Correa or the contracted billing service has my permission to bill my insurance company and to provide necessary information for the purposes of obtaining authorization for services, benefit information and payment.

_____ _____

Signature of Client **Date**