BRIGHTER DAYS
Therapy
Janelle Staviski, LMSW, CCTP

Client Information

Client Name: _____ Referred by: _____

Address (Street, City, State, Zip: _____

Email Address: _____ Phone Number: _____ (Cell / Home / Work)

Birthdate: _____ Gender: _____ SSN: _____

Relationship Status: Single / Married / Divorced / Widowed / Other Employment Status: None / Employed / Student

Responsible Party or Legal Guardian Information (if minor)

Parent/Guardian Name: _____ Phone Number: _____ (Cell / Home / Work)

Address (Street, City, State, Zip:_____

Primary Insurance Information

Insurance Company Name: _____

Insurance ID Number:_____ Group Number: _____

Name of Primary Insured: _____

Address: _____

Phone Number: _____ Employer: _____

Birthdate: _____ Gender: _____ Relationship to the Client: _____

Secondary Insurance Information

Insurance Company Name: _____

Insurance ID Number:_____ Group Number: _____

Name of Primary Insured: _____

Address: _____

Phone Number: _____ Employer: _____

Birthdate: _____ Gender: _____ Relationship to the Client: _____

X _____

Client / Parent / Guardian Signature Date

Patient OR Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims for services provided. I authorize payments of medical benefits to Janelle Staviski, LMSW