Lisa Dahlgren, Ph.D.
Licensed Psychologist
www.gentlespirittherapy.com

2190 S. Mason Rd
Suite 100
Des Peres, Mo 63131

Contact Information

Child's Name:_____Date of Birth:_____

Child's Address:_____Child's Sex:_____

_____

Mother's Name:_____Father's Name:_____

Mother's Phone:_____ __Father's Phone:_____

Mother's Address:_____Father's Address:_____

_____ _____

Insurance Information

Subscriber's Name:_____Subscriber's Birth Date:_____

Insurance Company:_____Subscriber's SS #:_____

ID#:_____Group #:_____

My signature below acknowledges that I understand that my insurance policy is a contract between me and my insurance company, and as such I am responsible for payment for the services I have requested from Lisa Dahlgren. I further acknowledge that I have contacted the insurance company and understand the benefits for myself or my child, and that I accept the determination of the insurance company regarding coverage of my claims filed for me by Dr. Lisa Dahlgren, Ph.D. `

Date:_____Signature:_____

Assignment of Benefits: I hereby assign payment of authorized medical benefits and/or psychological benefits, to include major medical benefits to Lisa Dahlgren, Ph.D. For any services furnished. I authorize any holder of medical information about me or my child to release any information needed to determine the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for charges whether or not paid by said insurance. In addition, my signature below acknowledges that I have been offered the privacy practices of this office.

Date:_____Signature:_____