

Lisa Dahlgren, Ph.D.

Suite 100

Licensed Psychologist
www.gentlespirittherapy.com

2190 S. Mason Rd.
Des Peres, MO 63131

Phone: 636-394-6210

Contact Information:

Name: _____ Date of Birth: _____ Sex: _____

Address: _____

Phone Number (best contact number): _____

Alternate phone number(s): _____

How were you referred? _____

Insurance Information:

Subscriber's Name: _____

Subscriber's Social Security Number: _____ Birthdate: _____

Insurance Company: _____

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 my insurance company and understand my benefits, including issues of deductible, copay, and coinsurance, and that I accept the determination of the insurance company regarding coverage of my clients 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 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: _____