

# ZACHARY SCHWARTZ, MSW, LCSW, LLC

## CLIENT INFORMATION FORM-(Adult)

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

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Insurance Company: \_\_\_\_\_

Insurance Cardholder's Name: \_\_\_\_\_

Insurance Cardholder's ID #: \_\_\_\_\_

### Assignment of Benefits

I authorize the release of any medical or other information necessary to process all insurance claims. I also authorize payment of any benefits to Zachary Schwartz, MSW, LCSW, LLC for services rendered. I understand that I am financially responsible for all services provided including copayments, deductibles, etc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_