



Thank you for choosing Mindful Solutions LLC and Welcome!

IMPORTANT NOTICE Only fill out section 1 if you are the patient. If you have a copy of the front and back of your insurance card, you can skip section 3.

1 FOR CLIENT USE

Client Name		Social Security Number		Date of Birth (MM/DD/YYYY)	
Gender Male Female	Marital Status Separated Single Married Divorced Other	Client's Employment Status Employed FT Student PT Student Other			
Home Address		City, State, Zip			
Billing Address		City, State, Zip			
Home Phone	Cell Phone	Work Phone		Emergency Contact	

2 FOR PARENT / LEGAL REPRESENTATIVE USE

Parent / Legal Representative Name		Date of Birth (MM/DD/YYYY)		Gender Male Female	
Home Phone	Cell Phone	Work Phone	Marital Status Separated Single Married Divorced Other		
Insured's Name		Insured's Social Security Number		Date of Birth (MM/DD/YYYY)	
Insured's Address		City, State, Zip			

3 INSURANCE COMPANY DETAILS

Insurance Company	Insurance Contact Information	Insured's ID Number	Policy Group Number
Plan / Program	Employer Information	Contact Information	
Employer's Address		City, State, Zip	

4 REFERRAL SOURCE

Referral Source Self-Referral Insurance List Primary Care Physician Other	If you have been referred by your primary care physician, may we send a Thank you letter? Yes No
Physician's Name	Physician's Address

My therapist and the staff of Dr. Debra Block & Associates Mindful Solutions LLC have my permission to leave messages on my voicemail regarding my Clinical and/or financial information YES NO

Patient Signature	Date (MM/DD/YYYY)
Witness Signature	Date (MM/DD/YYYY)