

**THERAPIST: Rockland County Counseling Services – Elena Hernandez-Cordova**

**TAX ID: 92-2822864**

**NPI: 1922785328**

**Address: 99 Main St, Nyack, NY 10960 845-540-1002**

**Patient Information Sheet**

**Date** \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO INSURED:  SELF  SPOUSE  CHILD  OTHER

STATUS:  SINGLE  MARRIED  OTHER  MALE  FEMALE

EMPLOYED  FULL-TIME STUDENT  PART-TIME STUDENT

IS CONDITION RELATED TO:

EMPLOYMENT:  YES  NO IF YES: CURRENT \_\_\_\_\_ PREVIOUS \_\_\_\_\_

AUTO ACCIDENT:  YES  NO  STATE OTHER ACCIDENT:  YES  NO

INSURED'S NAME \_\_\_\_\_

(if you, the client are also the insured, write: Same as Above. If you, the client are not the insured, please fill in)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

**OFFICE USE:** Doctor (if in a group) \_\_\_\_\_

Dx: \_\_\_\_\_

CPT: \_\_\_\_\_

Fee: \_\_\_\_\_ FIRST DATE OF SERVICE: \_\_\_\_\_

**Therapist: Rockland County Counseling Services –**

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PATIENT NAME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(from back of Insurance Card)

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_

GROUP/POLICY # \_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE):**

INSURED'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(from back of Insurance Card)

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_

GROUP/POLICY # \_\_\_\_\_

**For office use only:**

Effective date: \_\_\_\_\_ In Network \_\_\_\_\_ Out of Network \_\_\_\_\_

Copay: \_\_\_\_\_ Coinsurance: \_\_\_\_\_

Deductible: \_\_\_\_\_ Deductible Met for this year: \_\_\_\_\_

Authorization: \_\_\_\_\_

Spoke with: \_\_\_\_\_

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

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