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: _____

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:** _____