RECTOR
PSYCHOTHERAPY SERVICES

CARY RECTOR, M.S., LMHC
LICENSED MENTAL HEALTH COUNSELOR

TONJA S RECTOR, M.A., LMFT
LICENSED MARRIAGE AND FAMILY THERAPIST

PATIENT INFORMATION DATE_____

PATIENT NAME_____ DATE OF BIRTH_____

STREET_____ CITY_____ ST_____ ZIP_____

GENDER_____SS#_____EMPLOYER_____

WORK PHONE_____ HOME PHONE_____

CELL PHONE_____ NUMBER FOR APPOINTMENT CONFIRMATION _____

EMAIL ADDRESS_____

FINANCIAL RESPONSIBILITY (COMPLETE ONLY IF OTHER THAN PATIENT)

NAME_____ RELATIONSHIP TO PATIENT_____

STREET_____ CITY_____ ST_____ ZIP_____

MARITAL STATUS_____ GENDER_____ SS#_____ DATE OF BIRTH_____

EMPLOYER_____ ADDRESS_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____

INSURANCE INFORMATION (INSURANCE PAYMENT IS NOT GUARANTEED. ANY PORTION OF FEE NOT COVERED BY INSURANCE IS RESPONSIBILITY OF PATIENT/FINANCIALLY RESPONBILE PERSON ABOVE)

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____DATE OF BIRTH_____

NAME OF INSURANCE CARRIER_____PHONE _____

STREET OR PO#_____ CITY_____ ST_____ ZIP_____

SS#/ID#_____ POLICY#_____ GROUP#_____

EMPLOYER_____ PHONE_____

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim_____ Date_____

I authorize payment of medical benefits directly to the provider_____ Date_____

7000 E. GENESEE ST. FAYETTEVILLE, NY 13066 PHONE: (315)449-2300 FAX: (315)449-1177
WWW.RECTORPSYCHOTHERAPY.COM