Susan V. Sims, LMHC, MCAP
3502 Henderson Blvd; Suite 205; Tampa, FL 33609

Patient Information

Name_____ Today's Date_____

Address _____

City_____ State_____ Zip_____

Home Phone_____ May I leave a message? Yes _____ No _____

Cell Phone_____ May I leave a message or text ? Yes _____ No _____

Work Phone _____ May I leave a message? Yes _____ No _____

Email _____

May I email you? Yes ____No ____Would you like to receive email appointment reminders? Yes ___ No ___

DOB_____ Age _____ Marital Status_____ SSN _____

Spouse/Partner's Name _____

Employer_____

Emergency Contact Name:_____ Number:_____

Insurance Company/ Phone _____

Primary Insured Name_____ Insured SSN _____

Insured DOB _____ Insured Employer_____

Policy #_____ Group #_____

Referred By: _____

I authorize the release of any medical information to process this claim and request payment of benefits to either myself or to the party who accepts assignment below.

Signature_____ Date_____

I authorize payment of medical benefits to Susan V. Sims, LMHC, MCAP for professional services rendered.

Signature_____ Date_____

I accept financial responsibility for professional services rendered by Susan Sims, LMHC, MCAP.

Signature_____ Date_____