Client Information

First Name

Last Name

Date of Birth

Address

Phone #

Email

Emergency Contact Person

Name of local friend or relative

Relationship

Phone #

Alternative Phone #

Problems + Medical History

Medical Problems

Mental Health Problems/Hospitalizations

Medications, Herbs or Supplements

Billing Information

Check your preferred payment options for counseling services and/or co-payments:

☐ CREDIT CARD

Credit Card # ______________________ Expiration Date ______________________

Name on Card ______________________ CVC/CVV Code ______________________ Zip Code ______________________

I, ______________________ authorize TEJE ALIBERTI to charge my credit card above for agreed upon services. I understand my information will be saved for future transactions.

☐ VENMO: Teje-Aliberti

☐ PAYPAL: tejenancy@gmail / 310-995-9772

☐ WEBSITE: Use the payment/scheduling service on providers website.

Insurance Information

Name of Insured Person ______________________ Date of Birth of Insured Person ______________________

Insurance Provider Name ______________________

ID # ______________________ Group # ______________________

If I am not in-network for your insurance, verify directly with your insurance provider on your out of network behavioral telehealth coverage. I can provide a coded invoice so you can submit your claim forms directly to your insurance. Check if you need an invoice "superbill": ☐ Every session ☐ Every 4 sessions ☐ Every ____ sessions

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for any copay or balance. I also authorize TEJE ALIBERTI, LPCC & LMFT or insurance company to release any information required to process my claims.

Parent/Guardian Signature ______________________ Date ______________________