William F. Mecca, Sr., LCSW, LMFT, LADC
547 Evergreen Ave
Hamden, CT 06518
203-281-7699

Name: _____ Date of Birth: _____/_____/_____

SS#: _____ □ M □ F □ single □ married □ widowed □ divorced

Address: _____Town:_____ State:_____Zip:_____

Phone: _____Work: _____ Cell:_____

Primary Care Provider: _____ Referred By: _____

In an emergency, whom may we contact? Name:_____Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____/_____/_____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to patient: □ self □ spouse □ child □ other

Policy Holder's Employer: _____ □ full time □ part time

Seconday Insurance: _____ Effective Date:_____/_____/_____

ID #: _____Group #:_____

Policy Holder's Name: _____Relationship to patient: □ self □ spouse □ child □ other

Policy Holder's Employer: _____ □ full time □ part time

ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize direct payment of surgical/medical benefits to the provider, for services rendered by the provider in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the provider, to release any medical information necessary to process my claims and determine benefits payable.

MEDICARE/MEDICAID I hereby authorize payment of Medicare benefits be made to the provider on my behalf for services rendered. I authorize the release of any medical information needed to determine benefits or the benefits payable for related services.

Patient Signature_____ Date _____/_____/_____