Mary Galaszewski, Ph.D.
Fountain Plaza
505 S. 336th St., Suite 415
Federal Way, WA 98003
Phone: (253) 569-7698

Demographic Form

(Please Print)

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Social Security - -	Home Phone No. ( )

City	State	Zip Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. _____

Referred to Provider by (Please check one box & list) ❑ Insurance Plan

❑ Family ❑ Friend ❑ Dr. _____

Email Address:

INSURANCE INFORMATION (WILL NEED COPY OF YOUR INSURANCE CARD)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Please Select Your Primary Insurance Provider	❑ Premera ❑ Regence Blue Cross/Blue Shield ❑Aetna ❑ First Choice ❑ Magellan ❑ Medicare ❑ Value Options ❑ Self Pay _____

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) annnanapplicable)	Insured's Name	Group #	Policy #
Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other			

Agreement to Pay for Professional Services

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

X_____

CLIENT/GUARDIAN SIGNATURE DATE

Agreement to Pay for Professional Services

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Consent to Treatment

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Authorizations

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE