John A. Watterson, PhD, LMFT
4101 Parkstone Heights Drive, Suite 260
Austin, TX 78746

(Please print clearly) Date:

Patient Information

Name (*First, M.I., Last*):		
Street:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Social Security #:		
Date of Birth:	Sex: M F	
Marital Status: Single Married Widowed Divorced Legally Separated Partnered Minor		
Employment Status: Full-time Part-time Retired Non-employed		If Student: Full-time Part-time
Patient Employer:		
Patient School (if student):		
Occupation:		
Emergency Contact - Name:	Phone #:	Relation to Pt:
Whom may we thank for referring you?		

Primary Insurance

Name of Subscriber:	Patient Relationship to Subscriber: Self Spouse Child Other	
Address (if different from patient's)		
Street:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Subscriber's Social Security #:		
Subscriber's Date of Birth:	Subscriber's Employer:	
Insurance Co. Name:	Ins. Co. Street:	
Insurance Co. City:	Ins. Co. State:	Zip Code:
Ins. Co. Phone: ( )	Policy # / ID # :	
	Group #:	

Additional Insurance

Is patient covered by additional insurance? Yes No		
Name of Subscriber:	Patient Relationship to Subscriber: Self Spouse Child Other	
Address (if different from patient's)		
Street:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Subscriber's Social Security #:		
Subscriber's Date of Birth:	Subscriber's Employer:	
Insurance Co. Name:	Ins. Co. Street:	
Insurance Co. City:	Ins. Co. State:	Zip Code:
Ins. Co. Phone: ( )	Policy # / ID # :	
	Group #:	

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company(ies) and assign directly to John A. Watterson, PhD, LMFT, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named health care provider may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient