SUSAN DELLUTRI, LLC
1661 N. Water Street, Suite 413 Milwaukee, WI 53202 414-207-4107

Demographic Information - Adolescent

Name_____ Date of Birth_____
Address_____ Social Security_____
Apt/Suite_____ Gender_____
City/ST/Zip_____ Cell Phone (_____)_____

Parent #1 Name_____ Parent #2 Name_____
Address_____ Address_____
City/ST/Zip_____ City/ST/Zip_____
Cell (_____)_____ Cell (_____)_____
Home (_____)_____ Home (_____)_____
Work (_____)_____ Work (_____)_____
Relationship Status: M D S W P (Partnered) Relationship Status: M D S W P (Partnered)
Parent #1 may be contacted at home____Wk_____ Parent #2 may be contacted at home _____ Work_____

* I have specified contact/communication concern on back of form: Yes or No (circle one) W

Emergency contact person_____ Phone (_____)_____
Bills should be sent to_____
Payment Information: (please check) Self Pay_____ Insurance_____ HSA_____ Other _____
Referred by_____

Insurance information

Primary
Insurance Co._____
Policy Holder_____
Employer_____
ID#/Group#_____
Type of Coverage: Single or Family (circle)
Claims Address_____
City/ST/Zip_____
Phone (_____)_____
Effective Date_____

Benefits
In Network _____ Out of Network _____
Preauthorization needed? Yes_____ No_____
Authorization #_____
Number of sessions authorized_____
Authorization date _____ to_____
Deductible $_____
Copay per session % or $_____
Coinsurance_____%
Benefits for calendar year $_____

Secondary
Insurance Co._____
Policy Holder_____
Employer_____
ID#/Group#_____
Type of Coverage: Single or Family (circle)
Claims Address_____
City/ST/Zip_____
Phone (_____)_____
Effective Date_____

Benefits
In Network _____ Out of Network _____
Preauthorization needed? Yes_____ No_____
Authorization #_____
Number of session authorized_____
Authorization date _____ to_____
Deductible $_____
Copay per session % or $_____
Coinsurance_____%
Benefits for calendar year $_____

Assignment of benefits

Since my health insurance may cover the cost of service, I hereby authorize Susan Dellutri, LLC to release to my insurance company and/or contracted billing services only pertinent billing/diagnostic information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to Susan Dellutri, LLC for services rendered. **I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.**

Signature_____ Date_____
Parent/Guardian (if under 18)