SUSAN DELLUTRI, LLC

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

Demographic Information - Adult

Name	Date of Birth
Address_	Social Security
Apt/Suite	Gender
City/ST/Zip	Gender Relationship Status: S M D W P (partnered)
Home Phone ()	Employer
Cell Phone ()	Address
Email Address	City/ST/Zip
Email Address I may be contacted at home work	City/ST/Zip
* I have specified contact/communication concern of	on back of form: Yes or No (circle one)
Emergency contact person	Phone ()
Bills should be sent to	
Payment Information: (please check) Self PayReferred by	Insurance HSA Other
Insurance information	
Primary	Secondary
Insurance Co.	Insurance Co.
Policy Holder	Policy noidei
Employer	EmployerID#/Group#
ID#/Group#	ID#/Group#
Type of Coverage: Single or Family (circle)	Type of Coverage: Single or Family (circle)
Claims Address	Claims Address
City/S1/Zip	City/S1/Zip
Phone ()	Phone ()
Effective Date	Effective Date
Benefits	Benefits
In Network Out of Network	In Network Out of Network
Preauthorization needed? YesNo	Preauthorization needed? Yes No
Authorization #	Authorization #
Number of sessions authorized	Number of session authorized
Authorization date to	Authorization date to
Deductible \$	Deductible \$
Copay per session % or \$	Copay per session % or \$
Coinsurance % Benefits for calendar year \$	Coinsurance
Benefits for calendar year \$	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.

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Signature	Date
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