BRIGHTON THERAPY GROUP
Ruth Friga, LCSW-R, ACSW Psychotherapy, P.C.
JoAnn McDermott, LCSW-R, ASCW Psychotherapy, P.C.
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95 Allens Creek Rd, Executive Square, Building 2, Suite 16
Rochester, NY 14618

Patient Name _____ Social Security # ____ - ____ - ____
:
Date of Birth: _____ Marital Status _____ Gender: [ ] M [ ] F

Address: _____ Home Phone: (585) _____
(street name and number)

_____ Cell Phone: ( ) _____
(city) (state) (zip)

Patient's Employer: _____ Work Phone: ( ) _____

Emergency contact: _____ Phone: ( ) _____

Insurance Company _____ Insurance Co. ID Number: _____
(include all letters and suffix numbers)

Subscribers Name: _____ Subscribers DOB: _____ Relationship: _____

Legal Status (If applicable): _____

Guardianship (If applicable): _____

Primary Care Physician: _____ Phone Number: ( ) _____

Current Medications & Dosage: _____

Prescribed by: _____

Do you have any allergies: _____

Have you had any adverse reactions to medications or other substances:? If yes, please explain:

_____

Do you currently have a medical specialist? If yes, please list:

_____

E-Mail Address _____

Patient or Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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PLEASE NOTE: ALL INSURANCE COPAYS ARE DUE AT THE TIME OF SERVICE.
I authorize my insurance company to pay all services rendered to me by Brighton Therapy Group - Ruth Friga, LCSW-R, ACSW; JoAnn McDermott, LCSW-R, ACSW; M&D Schwab, LCSW-R, ACSW to be paid directly to the practice. I also understand I will be responsible for all amounts not covered by my insurance (or I am uninsured) and agree to pay such amounts. I consent to have Brighton Therapy Group use and disclose my patient information in order to process such claims on my behalf.