

Catherine Anne Walsh, Ph.D., P.A.

LICENSED CLINICAL PSYCHOLOGIST

RESPONSIBLE PARTY INSURANCE INFORMATION

CLIENT NAME: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Relationship to Insured: _____ SS#: _____

Home Phone: _____ Work/Cell Phone(s) _____

RESPONSIBLE PARTY (if client is a minor): _____

Address (if different): _____

Home Phone: _____ Work/Cell Phone(s) _____

NAME OF PRIMARY INSURANCE CO: _____

Name of Employee: _____ Employer: _____

SS/Policy#: _____ Group#: _____ Benefits Phone#: _____

Address: _____

NAME OF SECONDARY INSURANCE CO. (if any): _____

Name of Employee: _____ Employer: _____

SS/Policy#: _____ Group#: _____ Benefits Phone#: _____

Address: _____

» » » I authorize the release of medical information to insurance carriers and/or their agents.

Signed: _____ Date: _____

» » » I authorize payment of insurance benefits, for services rendered, to Catherine Anne Walsh, Ph.D..

Signed: _____ Date: _____

SERVICES FOR:

Children,
Adolescents,
Adults & Families

Marital &
Couples' Issues

Depression &
Anxiety Issues

Behavioral &
Family Issues

WHAT NEXT?

NEXT PHASE
OF LIFE
RETIREMENT
COACHING:

Evaluation

Individual
Adjustment

Marital &
Couples' Coaching

Shifting Gears

PLEASE PRESENT INSURANCE CARD(S) TO DR. WALSH SO SHE CAN MAKE A COPY.

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www.TalkingDoc.net