KAREN LEWIS, LCSW
101 Cedar Lane, Suite 201
Teaneck, NJ 07666

Patient Information

Patient's Name: ____ Date of Birth: ______________

Home Address: ____

City: ___________________________ State: _________ Zip code: __________________________

Home Phone: ________________________ Cell Phone: ___________________________

Employer: __________________________________ Work Phone: __________________________

Email:____

Name of Spouse, Parent or other Emergency contact (Please indicate): ____

Insurance Carrier: ___________________________________ Insurance ID#: _______________

Social Security Number of Policy Holder: ____

Date of Birth of Policy Holder: _____________________

Referral Source: ____

Family Physician: _____________________________ Tel: ________________________________

I have read and understood the above. I hereby give permission to Karen Lewis, LCSW to communicate with the above named contact if necessary and exchange information with my physician and Insurance Company.

I understand that there is a 24 hour cancellation policy and if I cancel less than 24 hours in advance, I will be required to pay the full fee which is ___________.
I give Karen Lewis permission to charge my credit card no: ________________________
Expiration date____________________ CVV_____________ if I do not cancel in 24hours.

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Print Name	Signature	Date