DEBBIE TESSMER-WAGNER, MA, LMFT (MFC#77147)
3633 Camino del Rio South, Suite 102
San Diego, CA 92108

Client Name _____ **Home Phone** _____

Address _____ **City** _____ **Zip** _____

Sex _____ **Age** _____ **Date of Birth** ___/___/___ **Social Security #** _____

Occupation _____ **Employer/School** _____

Work Phone _____ **Cell Phone** _____ **Marital Status** _____

Spouse/Partner Name _____ **Social Security #** _____

Sex _____ **Age** _____ **Date of Birth** ___/___/___ **Employer** _____

Occupation _____**Cell Phone** _____

IN CASE OF EMERGENCY, CONTACT _____ **Phone** _____

Children: **Name** _____ **D.O.B.** _____ **Living w/you Y** _____ **N** _____

Name _____ **D.O.B.** _____ **Living w/you Y** _____ **N** _____

Name _____ **D.O.B.** _____ **Living w/you Y** _____ **N** _____

Parent Information (IF PATIENT IS A MINOR)

Father _____ **Home Phone** _____

Address _____ **City** _____ **Zip** _____

Date of Birth ___/___/_____ **Social Security #** _____

Employer _____ **Work Phone** _____

Mother _____ **Home Phone** _____

Address _____ **City** _____ **Zip** _____

Date of Birth ___/___/_____ **Social Security #** _____

Employer _____ **Work Phone** _____

I was referred by _____ **Relationship to you** _____

☐ **I understand that the ultimate financial responsibility is mine whether I have insurance or not.**

Please sign below.

If you have insurance you intend for me to bill:
I will need a copy of the front and back of your insurance card to bill insurance.
Insurance is billed as a courtesy. It is important that you understand the following:

☐ I will be charged $50 for any missed appointment and for cancellations received less than 24 hours prior to my scheduled appointment time. **Insurance will not pay for missed appointments or late cancellations, and are my sole responsibility**
☐ I am responsible to obtain any preauthorization from my insurance company. If failure to do so results in non-payment from my insurance company, I understand I am financially responsible to pay for these sessions. I am responsible to pay for all deductibles and any balance remaining after insurance has paid their portion.
☐ I have read and understand the above. I authorize payment of authorized benefits to be made either to me or on my behalf to Debbie Tessmer-Wagner, MA, LMFT, for any services related to outpatient psychotherapy. I further authorize Debbie Tessmer-Wagner, MA, LMFT, to act on my behalf if it is necessary to file a complaint against my insurance company.

Signature _____ **Date** _____

Signature _____ **Date** _____