Eve Lievonen, PhD, LCSW

27001 La Paz Road, Suite 278A
Mission Viejo, CA 92691

901 Dove St, Suite 299
Newport Beach, CA 92660

Your Cell Phone ( )_____
Date_____ Home Phone ( )_____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor)_____

Street Address_____

City_____State_____Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____Birthdate_____

Business Name and Address_____

Occupation_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security Number_____ Spouse's Social Security Number_____

Do you have Medical Insurance? ☐ No ☐ Yes ► if yes,

Name of Primary Insurer_____

Contract #_____ Group #_____ Subscriber #_____

Name of Secondary Insurer_____

Contract #_____ Group #_____ Subscriber #_____

☐ Medicare ☐ Medicaid Claim ID#_____

If Welfare, your number_____County of_____

In case of emergency, who should be notified?_____ Phone_____

How did you learn of my practice_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Eve Lievonen, LCSW all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eve Lievonen, LCSW for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier

_____ _____
Beneficiary Signature Date