Eve Lievonen, PhD, LCSW

27001 La Paz Road, Suite 300B
Mission Viejo, CA 92691

901 Dove St, Suite 299
Newport Beach, CA 92660

Your Cell Phone ( )________________
Home Phone ( )________________

Date______________________

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, PhD___________ 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, PhD_________ 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

#22501.B Rev 03/07/2010