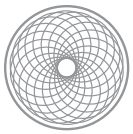


Westside Therapy

Leah DeSole, Ph.D.

## Client Information Form

210 West 70th Street, Suite 001
New York, NY 10023
(917) 757-5422
drdesole@westside-therapy.com

I, Dr. Leah DeSole, assume that I may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct me otherwise.

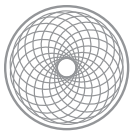
Under the federal Health Insurance Portability and Accountability Act (HIPAA) you have the right to request that communications with you be confidential and by means of your selection. I am obligated to honor your request as stated below, except if an emergency arises.

**I wish to be contacted as follows**: (check all that apply)

- At my home telephone number:
- At my work telephone number:
- Text message:
- In writing at this address:
- Email Address:

**I am electing to use insurance. My insurance information is**:

- My insurance provider is:
- My insurance member ID # is:
- My home address is:
- My date of birth is:
- My employer is:



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**IF THE INSURANCE IS IN ANOTHER PERSON'S NAME, e.g., spouse, parent or partner, please provide his/her information below**:

- His/her address is:
- His/her date of birth is:
- His/her employer is:

**Does your insurance require an authorization number?**

NO ☐

YES If yes, the number is:

My insurance copay amount is:

My insurance has authorized ☐ number of visits.

**Does your insurance require a referral number?**

NO ☐

YES If yes, the number is:

SIGNATURE:

PRINT NAME:

DATE:

**Please note: To cancel an appointment, please contact the office within 48 hours of your appointment or you will be responsible for payment.**