Thomas B. Allen, II, Ph.D., Director
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Susan A. Scott, LMFT
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Lisa Donovan, M.D.
James Archambeault, LADC
Ellen H. Pfarr, LCSW
Colleen Shay, Ph.D.
Tracy A. Shiring, M.S. ED
Tori Piraino, LMSW
Lucy Solari, LMFT

INSURANCE INFORMATION

Please complete all information accurately. Please have insurance card/s ready for required photocopy.

Insurance Company: ____

Policy #: ____________________ Group #: ________________ Effective Date: ______________

Person who carries the policy: ____
Name Date of Birth SS#

Employer Info: ____
Employer Name Relationship to patient

DO YOU HAVE SECONDARY INSURANCE? please complete section below:

Secondary Insurance Company: ____

Policy #: ____________________ Group #: ________________ Effective Date: ______________

Person who carries the policy: ____
Name Date of Birth SS#

Employer Info: ____
Employer Name Relationship to patient

EMERGENCY CONTACT INFORMATION:

NAME: ________________________________

ADDRESS: ________________________________

____

PHONE: (home)________________ (cell)________________ (work)______________

Relationship to patient: ________________________

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314 Flanders Rd., Suite 2 B, East Lyme, CT FAX: 860-691-1546
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