

# NEW CLIENT FORM

Mosaic Psychological Center, PLLC  
425 S. Sharon Amity Road, Suite D  
Charlotte, North Carolina 28211

## Patient Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Work/Other Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_ Gender \_\_\_\_\_  
Employment Status: Employed \_\_\_\_\_ Student \_\_\_\_\_ SAHM \_\_\_\_\_ Retired \_\_\_\_\_ Other \_\_\_\_\_  
Employer or School: \_\_\_\_\_  
If adolescent, list siblings' names and ages here: \_\_\_\_\_

## Primary Insured's Information

Patient's Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

(If patient relationship to insured is "self," skip this section. If adolescent, list both parents here.)

### Father

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### Mother

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Social Security No.: \_\_\_\_\_

## Primary Insurance Company Information

Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer or School Name: \_\_\_\_\_

In case of emergency, who should be notified: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

The undersigned have insurance coverage with \_\_\_\_\_ and assign directly to Mosaic Psychological Center, PLLC all medical  
(Name of Insurance Co.)

benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize Mosaic Psychological Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and updates. I understand that a charge is made for missed appointments not cancelled 24 hours in advance or 48 hours in advance for Monday appointments. **I will be charged \$80 for the first miss and \$165 for any subsequent misses not due to illness or emergency.** I understand I need to keep an active credit card on file and that the missed fee will be automatically billed by the end of that business day. If I contest the charge(s) and a chargeback occurs, I understand I will be responsible for that cost.

\_\_\_\_\_

Signature of Insured/Guardian

\_\_\_\_\_

Today's Date