

**Personal Information/ Insurance and Emergency Releases**

Name(s): \_\_\_\_\_  
\_\_\_\_\_

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

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

Phone Number(s) OK to leave a message on: \_\_\_\_\_  
\_\_\_\_\_

Email Address(es) \_\_\_\_\_

Date(s) of birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Employer/type of work: \_\_\_\_\_

Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

ID number: \_\_\_\_\_ Group/Plan number: \_\_\_\_\_

Insurance Co Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Provider Phone #: \_\_\_\_\_

**Emergency Notification Release of Information**

In the event of a medical or behavioral emergency while under treatment by Melissa Owens LPC, I authorize Melissa or her delegate to notify the following person:

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

Address/ Phone: \_\_\_\_\_

In the event that I need to be transported to a hospital for medical attention, I am to be sent to:  
\_\_\_\_\_

Unless I specifically revoke it in writing, this general Release of Information will remain in effect until I terminate treatment.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)