

**Advanced Behavioral Counseling**  
**93 Main St., Suite 1**  
**Newton, NJ 07860**  
**973-579-9394**

**Patient Information:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth date: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

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

**Responsible Party Information:** (If different from above)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth date: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

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

**Insurance Information:**

**Primary Insurance Company:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

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

Group Number: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

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

Group Number: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Referral Source \_\_\_\_\_

I, hereby, authorize Deborah Drumm to furnish the insurance company or others not authorized by law, with full information regarding treatment rendered, when so required. I, hereby, authorize my insurance company to pay directly to Deborah Drumm medical benefits otherwise payable to me and I will be responsible to Deborah Drumm for all expenses incidental to treatment rendered not paid under this plan.

In the event that my account is turned over to collections, I agree to pay all fees by the collection agency, including legal fees, as well as any other fees Deborah Drumm may incur as a result of turning my account over to collections.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Guardian (if required) \_\_\_\_\_ Date \_\_\_\_\_

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**INJURY INFORMATION**

Is this injury or condition relates to work \_\_\_\_\_ auto \_\_\_\_\_

If accident: Auto \_\_\_\_\_ Other \_\_\_\_\_

Claim #: \_\_\_\_\_ Name of Adjuster: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

City/State when injury occurred: \_\_\_\_\_

How did the injury occur? \_\_\_\_\_

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First date you were unable to work \_\_\_\_\_ Date returned to work \_\_\_\_\_

**IF CLAIMS ARE TO BE SUBMITTED THRU WORKERS' COMP,  
PLEASE SIGN BELOW**

In the event the claim for workers' compensation is declared fraudulent for this illness or condition, or it is determined by the Workers' Compensation Board that the injury or illness is not a compensable workers' compensation case, I hereby agree to pay Deborah Drumm for all services rendered.

I will be responsible to pay Deborah Drumm for all services rendered with regard to the discovery and treatment of any condition not related to workers' compensation injury or illness. I agree to pay for all services not covered by workers' compensation and all charges for treatment unrelated to my workers' compensation injury or illness.

In the event that I do not show up for an appointment, or I cancel an appointment that is scheduled within 24 hours, I agree to pay Deborah Drumm for the services associated with the missed or canceled appointment and I understand that the missed or canceled appointment will not be submitted to, or paid by, workers' comp.

Patient \_\_\_\_\_

Date \_\_\_\_\_

Guardian (if required) \_\_\_\_\_

Date \_\_\_\_\_