

Bridget StJohn Therapy (Bridget StJohn, LLC)

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Location: 105B W. Main Ave, Suite 115, Puyallup, WA 98371 Mail: 4227 S. Meridian, Ste C #176, Puyallup, WA 98373

Client Information

Name: _____

Date of Birth: ____/____/____ SSN: _____

Physical Address: _____
(street) (City) (State) (Zip)

Mailing Address: _____
(street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Text? Yes ____ No ____

Email: _____

Employment Status (employed, unemployed, retired, etc.): _____

In case of an EMERGENCY notify (spouse, parent, guardian, other):

Name: _____ Relationship: _____

Address: _____
(street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Text: Yes ____ No ____

Insurance Information

Primary Insurance: _____

Policy Holder Name: _____

ID Number: _____ Group Number: _____

Relationship to insured: Self ____ Spouse ____ Dependent ____

Secondary Insurance _____

I authorize Bridget StJohn Therapy (through Lori Kimmerly, PLLC) to bill my insurance company and to release information required to process any claims.

Client Signature: _____ Date: _____