

Brenda R. Kizor, M.A., M.F.T.
1801 Highway 50 East, Suite H
Carson City, NV 89701

Application for Service

Name of Patient: _____ Soc Sec No ____ / ____ / ____

Date of Birth _____

Address _____ City _____ State ____ Zip ____

Address _____ City _____ State ____ Zip ____

Mailing address (If different than above)

Email address: _____

If patient is a minor, name of parent or guardian: _____

Telephone Home _____ Work _____ Cell _____

Employer's Name and Address _____

Spouse's Name _____ Soc Sec No ____ / ____ / ____

Date of Birth _____

Insurance Information

Medical Insurance Co: _____

Name of Insured _____

Address: _____

Policy # _____ Group # _____

Family Members

List names and ages of all family members living at home of patient: _____

I am seeking help because: _____

I agree to pay the fee of \$ _____ per 50 minute session for services provided. I understand that I am responsible for the fee although my insurance may be billed. I also understand that I must give a 24 hour notice of cancellation or I will be charged for the missed appointment.

Applicant Signature

Date