



**Svetlana Libus, M.D.**  
*Child, Adolescent and Adult Psychiatry*  
*Board Certified*  
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Referred by: \_\_\_\_\_ Date: \_\_\_\_\_  
**Patient Name** \_\_\_\_\_ Birthday: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**RESPONSIBLE PARTY**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

**MINOR CHILD INFORMATION**

**Father:** \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work address: \_\_\_\_\_

**Mother:** \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work address: \_\_\_\_\_

**MEDICAL INFORMATION**

Reason for visit: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Current Medical condition: \_\_\_\_\_

**INSURANCE INFORMATION**

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowance or percentage based upon your contract with them, not with our office. It is your responsibility to pay by the end of each session. *(Exception: If you have United Healthcare or PacifiCare, you insurance will be billed first directly by our office. It is your responsibility to pay the deductible, co-payment or any other balance not paid by your insurance. Payment will be collected from you by the end of each session. )*.

Please be aware that if are unable to keep a scheduled appointment, 48 hours advance notice must be given or you will be charged for the time that was reserved for you.

**PRIMARY INSURANCE**

Company name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID # \_\_\_\_\_ Group# \_\_\_\_\_

**SECONDARY INSURANCE**

Company name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID # \_\_\_\_\_ Group# \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I authorize Svetlana Libus, M.D. to release any information including diagnosis and the record of any treatment rendered to me or my child during the period of such care to third party payers.

I authorize and request my insurance company to pay directly to Dr. Libus insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original

I have read this information as well as information presented on the website: libusmd.com and understand it.

Patient/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_