# CLIENT INFORMATION

**B. Eliot Singer, LPC, 1110 Rose Hill Dr., Suite 201, Charlottesville, VA 22903 (434) 220-3334**

CLIENT IS RESPONSIBLE FOR OBTAINING INSURANCE PREAUTHORIZATIONS, INSURANCE COVERAGE INFORMATION, AND CO-PAYMENTS/COINSURANCE AMOUNTS

CLIENT FULL NAME_____

CLIENT SS#_____DATE OF BIRTH_____

ADDRESS_____

TELEPHONE: HOME_____WORK_____CELL_____

CAN MESSAGES BE LEFT AT HOME?_☐_ AT WORK?_☐_ON CELL?_☐_

MARITAL STATUS_____GENDER: MALE_☐_FEMALE_☐_

RELATIONSHIP TO PRIMARY INSURED: SELF☐SPOUSE☐DEPENDENT☐STUDENT☐

**If client is a child under 18, please provide the following:**

MOTHER'S NAME_____SSN_____PHONE_____

FATHER'S NAME_____SSN_____PHONE_____

RESPONSIBLE PARTY NAME AND ADDRESS: _____

REFERRED BY_____PHYSICIAN_____

INSURANCE COMPANY NAME, ADDRESS, PHONE_____

PRIMARY INSURED NAME_____

PRIMARY INSURED SSN_____ DATE OF BIRTH_____

POLICY NUMBER_____ GROUP NUMBER_____

EMPLOYER_____ PHONE_____

CLIENT/THERAPIST AGREEMENT: I AUTHORIZE THE RELEASE OF ANY MEDICAL AND PSYCHOTHERAPY TREATMENT INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND/OR TO COMPLETE TREATMENT PLANS AS MAY BE REQUIRED BY MY MANAGED CARE COMPANY. I AUTHORIZE PAYMENT FROM INSURANCE TO BE MADE DIRECTLY TO B. ELIOT SINGER, MA, LPC. I UNDERSTAND THAT INSURANCE WILL BE FILED, BUT I OR OTHER NAMED RESPONSIBLE PARTY AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ACCOUNT REGARDLESS OF INSURANCE COVERAGE. CO-PAYMENTS, COINSURANCE, OR OTHER FEES ARE EXPECTED AT THE TIME OF SERVICE, UNLESS MONTHLY PAYMENT HAS BEEN ARRANGED WITH THE THERAPIST. THERE WILL BE A SERVICE CHARGE OF $25 FOR RETURNED CHECKS.

I UNDERSTAND AND AGREE THAT MISSED AND CANCELLED SESSIONS WILL BE CHARGED $75 IF NOT CANCELLED AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT TIME. MISSED AND CANCELLED SESSIONS CANNOT BE BILLED TO INSURANCE. IF MY ACCOUNT BECOMES DELINQUENT, I AM, OR OTHER NAMED RESPONSIBLE PARTY IS, RESPONSIBLE FOR COLLECTION AGENCY FEES AND/OR COURT COSTS.

SIGNED_____ DATE_____