## **CLIENT INFORMATION**

Ellen 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		
		H
ADDRESS		
TELEPHONE: HOME	WORK	CELL
CAN MESSAGES BE LEFT AT HOM		
MARITAL STATUS	GENDER: N	MALEFEMALE
RELATIONSHIP TO PRIMARY INSU	JRED: SELFSPOUSED	EPENDENTSTUDENT
If client is a child under 18, please p	rovide the following:	
MOTHER'S NAME	SSN	PHONE
		PHONE
RESPONSIBLE PARTY NAME AND	ADDRESS:	
REFERRED BY	PHYSICIAN	N
INSURANCE COMPANY NAME, AI	DDRESS, PHONE	
PRIMARY INSURED NAME		
		IRTH
	GROUP NUMBER	
		ONE
AND/OR TO COMPLETE TREATME COMPANY. I AUTHORIZE PAYMEN MA, LPC. I UNDERSTAND THAT IN PARTY AM ULTIMATELY RESPONS COVERAGE. CO-PAYMENTS, COIN SERVICE, UNLESS MONTHLY PAYM A SERVICE CHARGE OF \$25 FOR RI	NFORMATION NECESSARY TO ENT PLANS AS MAY BE REQUENT FROM INSURANCE TO BE NSURANCE WILL BE FILED, BE SIBLE FOR PAYMENT OF ACCUSURANCE, OR OTHER FEES AMENT HAS BEEN ARRANGED ETURNED CHECKS.	O PROCESS MY INSURANCE CLAIM JIRED BY MY MANAGED CARE MADE DIRECTLY TO ELLEN SINGER, BUT I OR OTHER NAMED RESPONSIBLE COUNT REGARDLESS OF INSURANCE ARE EXPECTED AT THE TIME OF D WITH THE THERAPIST. THERE WILL BE
SESSIONS CANNOT BE BILLED TO	INSURANCE. IF MY ACCOUNT	NT TIME. MISSED AND CANCELLED NT BECOMES DELINQUENT, I AM, OR DLLECTION AGENCY FEES AND/OR
CICNIED	DAS	DE.