

CLIENT INFORMATION

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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 ELEN 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 \$95 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 _____