

Date: _____

CLIENT INFORMATION

Name: _____ DOB: _____

Address: _____ City, State, Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

SS#: _____

Employer: _____ Occupation: _____

Employer Phone #: _____

SPOUSE INFORMATION

Name: _____ DOB: _____

Address: _____ City, State, Zip Code: _____

Phone # (indicate type): _____ SS#: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip Code: _____

Employer Phone #: _____

HOUSEHOLD MEMBERS

NAME	Sex	Age	Relationship	Education

OTHER INFORMATION

Physician: _____ Phone #: _____

Address: _____ City, State, Zip Code: _____

Office policy is for payment at time of service unless other arrangements were made. A 24-hour notice of cancellation is required.

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the therapist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance and/or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Primary Insurance Co.: _____ **Phone #:** _____

Effective Date: _____ ID#: _____ Group#: _____

Subscriber: _____ Relationship to Subscriber: _____

Subscriber's DOB: _____ Employer's Name: _____

Secondary Insurance Co.: _____ **Phone #:** _____

Effective Date: _____ ID#: _____ Group#: _____

Subscriber: _____ Relationship to Subscriber: _____

Subscriber's DOB: _____ Employer's Name: _____

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Release of Information

I authorize the release of all psychological information necessary to process all claims and that is pertinent to my health care. I assign all health benefits, including major medical benefits to which I am entitled, to Roseanne Myers, MS, LPC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Office Policy

Payment is due at time of service, unless prior arrangements were made. A 1.5% interest will be added to all outstanding charges (90 days old). Lack of payment could result in termination of services. A 24-hour cancellation notice is requested to avoid a charge of 1/2 the cost of the appointment. If you miss two (2) consecutive appointments by either no show or late cancellation, your case may be closed and your therapist will refer you elsewhere.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

CLIENT SIGNATURE: _____ DATE: _____