Client Information Form

Client Name_____
Must be full, legal name

Today's Date:_____ New Client? □ Y □ N Client Update? □ Y □ N

Client Information

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender □ M □ F

Home Phone _____ □ Y □ N
May I leave a message?

Work Phone _____ □ Y □ N
May I leave a message?

Other Phone_____ □ Y □ N
Please identify May I leave a message?

Client Marital Status
□ Married □ Single □ Other

Client Employment Status
□ Full Time □ Part Time □ None

Client Student Status
□ Full Time □ Part Time □ None

Billing/Responsible Party Information *only complete information that differs from the client*

Name_____ Home Phone_____

Address_____ Work Phone_____
Street or PO Box

_____ Relationship to Client:_____
City State Zip

How Did You Hear About My Practice?

□ Current/Former Client □ Healthcare Professional □ Yellow Pages □ Mental Health Provider

□ Insurance Company □ Word of Mouth □ Other Name _____

Insurance Information *A copy of the insurance card must accompany this form.*

Insured's Name_____ Insured's Social Security No_____

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other

Insured's Address _____ Home Phone_____
*If differs from client Street or PO Box

_____ Other Phone_____
City State Zip

Insured's DOB_____ Gender □ M □ F Insured's Employer_____

Therapist Use Only: Therapist Name_____ Diagnosis Code_____

□ Bill SOVA □ Bill Adoptions □ Bill Secondary Insurance □ Worker's Compensation

Billing Notes_____

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Assignment of Insurance and Release of Information

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider of the service and is not a substitute for payment. Some companies will pay fixed allowances for certain types of service and others pay a percentage of the charge. They do not pay at all for some services. It is the patient's responsibility to pay any deductible amount, insurance co-payment, or any other balance not paid for by his/her insurance company. If we are filing your claim we will allow forty-five days from the billing date for the insurance company to process your claims and make payment accordingly. If payment from your insurance carrier is not received within that time frame we will notify you and expect you to pay the balance of your account and seek reimbursement for yourself directly from your insurance company. Any other arrangement must be made in advance and in writing with your individual therapist.

Your signature below certifies the following: I have read and understand fully this billing policy and agree to make payment in full and/or satisfactory arrangements if asked to do so as specified above. I understand that I am financially responsible for any amount of unpaid deductibles, all charges and/or co-payments whether or not paid by my insurance company. I specifically grant permission for Dr Martha Durham or her representative to contact me at my work number _____ and/or at the following authorized number(s) _____ for the purpose of resolving my bill should you be unable to reach me at home. Should my account be referred for collection to an attorney or collection agency, I shall pay reasonable attorney's fees, court fees and collection expenses. I hereby authorize Dr Martha Durham or her representative to release all information necessary to secure payment. I hereby assign all benefits to which I am entitled, including private insurance, Worker's Compensation, Victim's Compensation, etc. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient Name-**Please Print**

_____

Name of Responsible Party-**Please Print**
*If different from Patient

_____ _____

Signature of Patient or Responsible Party Date