PATIENT FINANCIAL INFORMATION

Name:_______________________________________ Date of Birth:_____________

Gender: M____ F____ Transgender______

Address: _____________________________________ City: ________________ State:_____ Zip:_______

Home Phone: ____________________ Cell Phone: __________________Work Phone: ______________

Parent/Guardian/Spouse: ____ Phone: __________________

PERSON RESPONSIBLE FOR THIS ACCOUNT

IF THIS INFORMATION IS THE SAME AS CLIENT INFORMATION YOU MAY SKIP THIS SECTION

Name ____ Relationship to Patient ______________

Address ____

City ________________________________ State _______ Zip __________ Phone (____) _____________

INSURANCE INFORMATION

Primary Insurance: _____________________________________ Phone: ____________________________

Billing Address: __________________________________City: _____________________ Zip: __________

Subscriber: _____________________________________ Subscriber Date of Birth: __________________

Subscriber Employer: ____

Subscriber ID: _____________________ Group #: _____________________ SSN:____________________

Do You Have Any Additional Insurance? ____ Yes ____ No **If Yes, Please Complete the Following:**

Insurance Company: _____________________________________Phone: ____________________________

Billing Address: __________________________________City: _____________________ Zip: __________

Subscriber: ______________________________________Subscriber Date of Birth: ___________________

Subscriber Employer: ____

Subscriber ID: _____________________ Group #:_____________________ SSN: ____________________

INSURANCE ASSIGNMENT/RELEASE & AGREEMENT

I, ___________________________________, authorize my insurance benefits to be paid directly to Brenda Newell, LICSW. I understand I am financially responsible for non-covered services, as well as any unpaid charges based on my insurance coverage. I authorize Brenda Newell to release any information required to process my insurance claim(s). I understand I may incur a missed appointment charge if I do not arrive for my scheduled appointment, or if I do not cancel my appointment 48 hours prior.

Patient/Guardian Signature: __________________________Date: _________________________

Dx 1:__________________________ Dx 2:________________________ Auth:______________________