Supportive Counseling Services, PLLC

Mental Health/Substance Abuse Counseling and Assessments

Date: _____

Name:_____

Date of Birth: _____ **Age:** _____ **Gender: M**_____ **F**_____

Address: _____
Street City/State Zip Code

Home: ( ) _____ **W:** ( ) _____

Cell: ( ) _____

OK to call/leave msgs at all #s? Yes_____ **If not, pls specify:** _____

Email: _____

Employment/School:

_____
Place of work/school name Occupation/year in school

Spouse/Partner's Name: _____

Emergency Contact:

_____
Name Phone Relationship

Primary Care MD:

_____
Name Phone

How did you hear about my services? _____

I, client, agree be responsible for timely payment **for all services received, as a self-pay client OR should insurance refuse to pay for services rendered:**

_____ _____
Client Signature **Date**

Supportive Counseling Services, PLLC

Mental Health/Substance Abuse Counseling and Assessments

INSURANCE: *If you are using insurance, please complete the following Sections 1 & 3 (and, if applicable, Section 2) & also be sure to provide an up-to-date copy of your insurance card.*
Please note that you are responsible for notifying your insurance carrier about your plan to attend treatment and for finding out whether you need prior approval. You are also responsible for keeping track of the number of allowed sessions remaining *and for letting me know right away any time your policy or its benefits change. Thank you for your assistance with this.*

1. Insurance Plan Name _____

Name of policy-holder: Self _____ ****Other:** _____
***Please make sure you complete Section 2 below*

Group #_____ **Policy #**_____

Benefit Package #_____ **Subscriber #**_____

Account #_____ **SSN of Policy-holder** _____-_____-_____

Insurance card phone # for providers or benefits_____

Co-payment: $_____ *or* _____**%** *per* **session. Total # sessions covered/year**_____

Have you seen another therapist this year? No_____ **Yes**_____**: # of visits used** _____

Deductible? No____ **DK**____ **Yes $**_____**: Deductible met? Yes**_____ **No**_____ **DK**_____

*2. **OTHER: If a person other than yourself is responsible* **for payment** – *or* – **if the holder of the insurance policy you are using, please provide information about that person:**

_____
Name **Street/City** **Zip code**

Phone H: (**)** _____ **W: (** **)** _____

Cell: (**)** _____

SSN _____-_____-_____ **Birth date** _____ **M**_____ **F**_____

Relationship to you_____ **Employer**_____

3. If using insurance, please sign in both places below:
CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim.

Signed_____
Date

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of insurance/medical benefits to Supportive Counseling Services, PLLC.

Signed_____ **Date** _____