

TERRI CLINTON-DICHISER, MA, JD, LCPC, NCC
CLIENT INFORMATION

All information is required.

DATE: _____

CLIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: FEMALE MALE MARRITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER _____

HOME PHONE #: (____) _____-____ WORK PHONE #: (____) _____-____ CELL/PAGER PHONE #: (____) _____-____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____

CLIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER _____

CLIENT'S EMPLOYER INFORMATION / STUDENT STATUS: (circle one) Full-time Part-time Unemployed Self-employed Retired Unemployed

COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE #: _____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: FEMALE MALE DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____

HOME PHONE #: (____) _____-____ WORK PHONE #: (____) _____-____ CELL/PAGER PHONE #: (____) _____-____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: (circle one) Full-time Part-time Unemployed Self-employed Retired Unemployed

COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE #: _____

PRIMARY INSURANCE INFORMATION

Copy of card received: Yes No

EFFECTIVE DATE: _____ INSURANCE COMPANY: _____

PHONE: _____ CLAIMS MAILING ADDRESS: _____

SUBSCRIBER'S NAME: _____ ID #: _____

GROUP NAME: _____ GROUP #: _____ CLIENT RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER ADDRESS: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____ SEX: FEMALE MALE

HOME PHONE #: (____) _____-____ WORK PHONE #: (____) _____-____

SECONDARY INSURANCE INFORMATION

Copy of card received: Yes No

EFFECTIVE DATE: _____ INSURANCE COMPANY: _____

PHONE: _____ CLAIMS MAILING ADDRESS: _____

SUBSCRIBER'S NAME: _____ ID #: _____

GROUP NAME: _____ GROUP #: _____ CLIENT RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER ADDRESS: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____ SEX: FEMALE MALE

HOME PHONE #: (____) _____-____ WORK PHONE #: (____) _____-____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a \$2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

*Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.*

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____
CHILD, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ **RELATIONSHIP:** _____

ADDRESS: _____
