Client_____ (DOB) _____Phone (C)_____

Address: _____Phone (H)_____

City _____Zip_____Phone (W)_____

Gender: M __ F __ T__ M-F___ F-M____ Other_____ Preferred Pronouns: _____

Marital Status: Married __ Single ___ Alternative Relationship___ Other _____

E-mail _____

If client is a dependent/minor, please give address and phone information of parent/guardian the client lives with:

_____ _____ _____

Name Address Phone

PRESENTING PROBLEM: _____

How were you referred to me? _____

WILL YOU BE USING YOUR INSURANCE? □YES □NO If so, please provide all insurance information.
If you are a self/cash-pay client, please provide information needed where indicated.

INSURED/BILLING INFORMATION

Person responsible for payment: _____Phone: _____

Relationship to the client: _____Phone: _____

Address: _____Date of Birth: _____ Employer: _____

****A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED**
All information must be completed prior to your first visit.

Patient Name: _____Policy Holder: _____

Primary Insurance: _____Effective Date_____

Secondary Insurance: _____Effective Date_____

Prior to your first visit please call the phone number on the back of your insurance card and ask the following questions:

1. What are my benefits for "in network outpatient behavioral health"?

   A. Amount of copay/co-insurance? _____

   B. How many sessions are allowed? _____

   C. Do I have to satisfy a deductible/how much? _____

2. Do I need prior authorization to be seen by this therapist? (Please use this section if you are using EAP)

   A. If yes, what is the authorization # _____ (Auth. Number for EAP)

   B. Number of sessions approved _____

   C. Name of rep & date of your phone call _____

3. Is my therapist covered under my benefits package? Yes ___ No ___

   A. If "No," what are my "out of network" benefits? _____

Address where insurance claims should be sent:

_____

_____

_____

ASSIGNMENT OF BENEFITS /AGREEMENT FOR PAYMENT HEREBY AUTHORIZE

I authorize payment to be made directly to Hope in Healing, Inc. of any insurance benefits covering my care.

I understand as signee that I am financially responsible to Hope in Healing, Inc. for all charges that are not covered by the insurance company.

I give Hope in Healing, Inc. Permission to release HIPPA COMPLIANT information obtained during treatment that is necessary support any insurance claims on this account.

SIGNED: _____ Date: _____

THERAPIST: _____ Date: _____

Cash/Self-pay: I agree to pay the fee of **$**_____ prior to attending scheduled sessions using the following payment method: **PayPal___ Venmo___ Check___ Cash___ Other_____**

Signed: _____ Date: _____

Revised 01/12/2021.