

Living Well Counseling Services, LLC

Clinician _____

Billing Information

Diagnosis _____

Patient's name _____ Date of birth _____

Child's parent or guardian name _____ Patient's SS# _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work phone _____ Cell _____

Is it okay to call you at work? Yes No email _____ Is it okay to email you? Yes No

Employer's Name _____ Employer's telephone number _____

Marital Status (circle one) Single Married Other Referred by _____

BILLING INFORMATION:

Person responsible for payment of bill (if different from above) _____

Address (if different) _____ State _____ Zip _____

Relationship to client _____ Employer _____

INSURANCE INFORMATION:

Insurance Company _____

Address where claim is to be sent _____

City _____ State _____ Zip _____

Name of insured person _____ Relation to client _____

Birth date of insured person _____ Employer _____

Subscriber Number _____ Group Number _____

Deductible? Y/N How much? _____ Co-pay? _____ Effective Date _____

Secondary Insurance

Insurance Company _____

Address where claims is to be sent _____

City _____ State _____ Zip _____

Name of person insured _____ Relation to client _____

Birth date of insured person _____ Employer _____

Subscriber Number _____ Group Number _____

The client is ultimately responsible for the payment of all services received at Living Well Counseling Center. If LWCS bills a medical insurance company for services, this is done as a courtesy to the client and is not a substitute for the client's responsibility for payment of services.

Payment Options: _____ Insurance coverage. Client is responsible for co-payments at time of each session.

_____ Pay cash or check at each appointment. (Please circle your preference.)

_____ Make individual arrangements for monthly payments with your therapist.

Appointment cancellations: Appointments which are cancelled with less than 24 hours notice may be billed to the client. Insurance companies do not pay missed appointment charges.

Fee: Your fee will be _____ per 50-60 minute session.

Other conditions: _____

Assignment of benefits

I hereby assign mental health/psychotherapy benefits to which I am entitled (including Medicare, private insurance and other health plan benefits) to Living Well Counseling Center, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original copy. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee Living Well Counseling Center, LLC, to release all information to secure payment on my behalf.

Signature of client/guardian _____ Date _____