Actively Engaging in your Journey of Creating Balance LLC

Client Information:

Client Name:_____ Date__/__/__
Age:____ Birthdate:__/__/__ Male__ Female__ Single__ Married__
Divorced__ Separated__ Widow/er__
Address:_____
City, State, Zip_____ Referred By:_____
Home Phone___-___-____ Cell Phone ___-___-____
Employer_____ Occupation_____
Work Phone ___-___-____
Which phone number is best to communicate with you:
home__ cell__ work__
Which numbers may I leave a voicemail message _____
Emergency Contact:_____ Relationship:_____
Cell:___-___-____ Home:___-___-____Work:___-___-____

Who is Responsible for this account? Who is insured?

Name:_____ Relationship to Client:_____
Cell#___-___-____ Home#___-___-____
Work #___-___-____
Subscriber's Employer:_____
Insurance Company_____
Insurance Company Phone for mental health___-___-____
Subscriber's ID#_____
Subscriber's Group #_____

Authorization and Release:

- I authorize the release of necessary information to third party payers/insurance companies and/or other health practioners.
- I authorize/request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- It is my responsibility to ensure therapist is in my insurance network and to verify my insurance benefits for treatment.
- I am informed of HIPPA guidelines and regulations related to confidentiality of medical records.
- I agree to be responsible for payment of all services rendered on my behalf or for my dependents: $___.__ for Initial session and $___.__ per 45-50 minute sessions. Copays are due at time of session.
- I agree to notify you 24 hours in advance of rescheduling or canceling my session. Insurance companies will not pay for missed or cancelled appointments. If I do not give 24 hour advance notice I will be responsible for a $__.__ cancellation fee. Repeated no show sessions will result in discharge.
- I agree to pay for professional services provided outside of therapeutic sessions such as therapeutic or emergency phone calls at a rate of $__.__ per 30-45 minutes.
- I acknowledge receipt of Creating Balance LLC's Notice of Privacy Practices Regarding Health Information and have had the opportunity to review and understand said practices, to review my concerns and questions.

Client Name:_____Date:__/__/__

Client Signature:_____Date:__/__/__

Parent or guardian signature, if client under the age of 18
_____Date:__/__/__

Witness Signature _____Date:__/__/__