Counseling Associates for Well-Being

Data Sheet

Todays date:___________

Name:________________________________ Email__________________________________

Name you prefer to be called:____________ Social Security #____________________

Date of Birth:_______________________ Race:_________________Gender:__________________

Marital Status_______________Spouse/Partner name_______________________

Spiritual Preference_________________________

Address:____ City________________Zip__________

Home Phone:________________ Work phone:________________ Cell/other:________________

May we leave a message at: Home____ Work____ Cell/other____? What is the best time to reach you?
____

Would you like an appointment reminder by text or email? ____ If so at what number or email?
____

Emergency Contact Name:_________________________Phone____________________

Relationship to you____________________

Referred by: __________________________ May we contact them to thank them for the referral? ______

If you were not referred, how did you find out about us? __Facebook, __Google, __Psychology Today,
__Radio Ad, __Friend or Family, __Other:_________________

Occupation:____________________ Place of Work:__________________________________
Full-time student?___ Number of hours per week that you work:___
Highest education level: _______________________

Briefly describe the main reason that you are here for care:

Insurance/ Payment Information:
__ I do not wish to use insurance at this time. I understand that if this changes, I will inform my clinician. In this event, I understand that my clinician will only bill from the date of change going forward (no retroactive billing). Sign:___________________________________ Date:_____________
__I have reviewed my clinician's fee sheet, and agree to the fee.

Name of insured if different than Client____

Employer_______________________________________

Insured's SSN_____________________ Insured's DOB____________________

Relationship to client______________________

Insured's Address:______________________________

Insurance Company___________________Plan name_______________________________

Member ID#_________________ Group#____________________

Phone # (on back of card)___________________________

Claims address____

Have you called for authorization and to confirm mental health benefits as well as information regarding co-pays or deductible? ________ Please supply all information from confirmation call below.
(As stated in our Professional disclosure, it is your responsibility to call regarding authorization and benefits. You will be charged full session fees until coverage is confirmed.) Please contact our office manager for assistance with this if needed *prior* to your appointment.

Policy effective date ___________________ Ded. Amount for ind.______________ Fam________________
Combined w/ medical?_________

Amount met__________________Policy covers LCSW/ LPC/LMFT?_______Therapist in network?_______
Out of network benefits?___________

Number of visits allowed annually?_______Copay________
Authorization needed?_____If so,authorization code?_________________

Authorization units________CPT code_______CPT code______
Date range authorization: from ______to_______

Referral needed? _____ **Do you have any Medicare Benefits?____**

Clinician's Name:_____________________________________