CLIENT BILLING INFORMATION

Client Information: **Client File #:** ____________________

Name ____ ☐Female ☐ Male
First Middle Initial Last

Mailing Address ____
Street City State Zip

Primary Phone______________________________ May I call/leave a Voice Mail ? ☐ yes ☐ no
Text Message ? ☐ yes ☐ no

Email address ____
May I communicate with you using email? ☐ yes ☐ no

Birth Date ________________ Age ________ SS# ____________________
(Billing purposes only)

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Other ____________________

Billing/Insurance Information:

Responsible Party ____

Relationship to Client: ☐ Self ☐ Spouse ☐ Domestic Partner ☐Child ☐ Other: ____________________

Address (if different from client) ____
Street City State Zip

Employer ____

Insurance Company ______________________________Co-Pay Amount____________________

Insurance Billing Info *(or copy of front and back of card)* ______________________________

Subscriber ID/Claim # ____________________________Group #: ____________________

I understand that some of my personal health information may be released to my insurance company. I state that I have insurance as noted above and assign all benefits payable directly to PROVIDER. I understand that my insurance company is billed as a courtesy to me and agree by signing below to pay the charges in full in the event of non-payment by my insurance company within 30 days of billing. I understand that it is my responsibility to be aware of and meet referral requirements of my insurance plan and that I will be responsible for payment if claims are denied due to miss-compliance with requirements of coverage reimbursement. I authorize PROVIDER and CSMI, for billing service to release all information necessary (including progress notes) to my insurance company to secure payment of benefits. By signing below I am consenting to the release of this information.

Client Signature: ______________________________________ **Date:** ____________________

Provisional Diagnosis: ____ (11.2015)