ENVISION
INTEGRATIVE THERAPIES

EAP 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 _____
Can I communicate with you using email? ☐ yes ☐ no

Birth Date _____ Age _____ SS# _____
(Billing purposes only)

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Other_____

EAP Information:

EAP Services Provider _____ Customer Service Phone: _____

Mental Health Benefits Provider: _____

Employer _____ Position _____

Authorization Number _____Approved Sessions _____

I understand that some of my personal health information may be released to my EAP insurance service. I state that I have insurance as noted above and assign all benefits payable directly to PROVIDER. I understand that it is my responsibility to meet any referral requirements of my EAP insurance plan and that I will be responsible for payment if claims are denied due to eligibility or other referral stipulations. EAP clients will not be billed for approved sessions. I authorize PROVIDER 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:** _____ (9.2015)

Steffie Genevieve, MSW, LICSW, CDP, SAP
Therapist and Personal Coach

www.envisionintegrativetherapies.com