CHARLOTTE UNDERWOOD

LMHC, PLLC - info@charlotteunderwood.com - (360) 333-2682

Confidential Client Information

Client Name: _____ Birth Date: _____

Name of person filling out this form if different from above: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Best way to contact you: _____

Emergency Contact: _____ Relationship to you: _____

Address: _____ Phone: _____

Physician's Name: _____ Phone: _____

Medications you are taking: _____

Name of person who referred you: _____

Insurance information

Insured's Name: _____ Insured's Birth Date: _____

Your relationship to the insured? ( ) Self ( ) Spouse ( ) Child ( )Other

Insured's Address (if different than above): _____

City: _____ State: _____ Zip code: _____

Name of Your Primary Insurance Carrier: _____ Plan Name: _____

Policy or ID Number: _____ Insured's Group Number: _____

Insured's Employer: _____

Insurance Company Address & Phone Number : _____

Deductible: _____ Copay/Coinsurance Amount: _____ Effective Date: _____

No insurance

Please sign here if you are paying out of pocket (no insurance) and you agree to pay my hourly fee at the time of service unless we make other arrangements:

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Release of Benefits and Information

I authorize my insurance benefits to be paid directly to my provider. I am financially responsible for insurance information provided and any balance due, regardless of satisfaction of services. I authorize Charlotte R. Underwood or the insurance company to release any information for this claim. Late fees will be charged on all outstanding balances.

Signed: _____ Date: _____

In addition to filling out the above information below, please attach a photocopy of both sides of your insurance card. Also, if you have a Secondary Insurance Company, please fill out the information on the rest of this form!

Secondary Insurance Company

Insurance Company: _____

Insurance Billing Address & Phone number: _____

_____

Insured ID Number: _____ Insured Group Number: _____

Insured's full name: _____

Insured's Date of birth: _____ Social Security Number: _____

GUARANTOR - Person Responsible for Payment

Full Name: _____ Circle One: Male Female

Street Address: _____

City/State/Zip: _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Relationship to Patient: _____

Relationship to Insured: _____