

OFFICE USE ONLY

Therapist _____ Photo ID _____
 Omaha Fremont Red Oak Co Bluffs (circle)
 Info Legible/Complete _____ Fee Agree _____
 Lg Ins Card _____ Elig/Ben _____ Confirm Pay _____
 Scanned _____ Initials _____ Date _____

CLIENT INFORMATION

Client Legal Full Name: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Policyholder SS#: _____ (required by some ins cos.)
 Client DOB: _____ Gender: Male () Female () Race: _____ Age: _____
 County of Residence _____ Single () Married () Divorced () Widowed () Child ()
 Is this a Minor? _____ If so, Policyholder Name: _____ Address, if different: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Employer: _____ E-mail: _____
 Emergency Contact Name & Phone Number: _____

FAMILY INFORMATION

Name	Date of Birth	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIMARY INSURANCE COVERAGE INFORMATION

Primary Insurance: _____
 Insurance Address/Phone: _____
 Insured Name: _____ M () F () Insured DOB: _____ Relationship: _____
 Insurance Type: Aetna () BCBS () Cigna () Tricare () Midlands Choice () Other () _____
 Policy#: _____ Grp#: _____ Deductible?: \$ _____ Deductible Met?: Yes or No
 Co-pay?: Y/N. If yes, Amt: \$ _____ Do you have Out-of-Network benefits? _____ Is an Authorization required? _____

SECONDARY INSURANCE COVERAGE INFORMATION

Secondary Insurance: _____
 Insurance Address/Phone: _____
 Insured Name: _____ M () F () Insured DOB: _____ Relationship: _____
 Insurance Type: Aetna () BCBS () Cigna () Tricare () Midlands Choice () Other () _____
 Policy#: _____ Grp#: _____ Deductible?: \$ _____ Deductible Met?: Yes or No
 Co-pay?: Y/N. If yes, Amt: \$ _____ Do you have Out-of-Network benefits? _____ Is an Authorization required? _____

- 1) I hereby give consent to Spence Counseling Center for myself and/or my dependents in the evaluation and treatment regarding my therapy that may be advisable or necessary in their opinion.
- 2) I authorize any holder of medical information on myself and/or my dependents to release said information needed to determine benefits payable for medical services. I further authorize payments for services furnished to myself and/or my dependents be made payable to Spence Counseling Center.
- 3) I understand and agree that **I must notify Spence Counseling Center within 24 hours to cancel or change an appointment** for myself and/or dependents. **If not, I will be billed and agree to pay the full session fee.**
- 4) I agree to notify Spence Counseling Center as soon as possible if my name, address, phone, or insurance information changes. If insurance coverage changes, I will bring in the card(s) as soon as possible.
- 5) **Having insurance coverage does not guarantee payable benefits. I understand that I am responsible and agree to pay for any deductibles, co-pays, or any amounts not covered by my insurance.**
- 6) **Any past due fees of balances over \$200.00 and/or later than 60 days will accrue a monthly 2% late charge to my account.**
- 7) This consent shall hold valid for this and all future visits unless revoked in writing. My signature demonstrates that I have read, understand, and agree to the above.

 Client/Guardian Signature Print Name Date Signed

 Client/Guardian Signature Print Name Date Signed