Print Form

COUNSELING ASSOCIATES, LLC

Patient Information

Date: Name: DOB: Age:

Marital Status: Social Security #:

Address: City: State: Zip:

Please indicate order of call preference by 1, 2, and 3.

Home: Work: Cell:

Parent/Spouse/Emergency Contact Information

Name: Social Security #: DOB:

Address: City: State: Zip:

Employer: Home Tel #: Work Tel #:

Primary Insurance Information (Responsible Party)

In most cases Counseling Associates will bill your insurance company for payment due, (other than your copay). Please be sure to accurately list all primary insurance information, as failure to do so may result in claims denial and make you responsible for the entire amount due. It is also necessary for you to inform us of any changes to your policy to avoid potential billing errors. Counseling Associates does not bill for secondary insurance. Upon Counseling Associates' submission to your primary insurance, you will receive a receipt from the primary insurance company which you will use to submit for your secondary insurance filing.

Subscriber Name: Policy #: Group #:

Subscriber DOB: Subscriber Social Security #:

Subscriber Employer: Insurance Company:

Patient Bill of Rights

My signature acknowledges that I have been made aware of the Patient Bill of Rights as posted in the Reception area or on this web site.

Signature: _____ Date: _____

Primary Care Physician

Primary Care Physician: Telephone:

I give permission to contact my primary care physician if medically necessary: ◯ Yes ◯ No

Signature: _____ Date: _____