



## CLIENT DEMOGRAPHIC FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_

Marital: M S W D

Gender M F

Client Social Security # \_\_\_\_\_ Client Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other / Cell \_\_\_\_\_

**IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX**

**HOME:**

Permission to call you Y N

**WORK:**

Permission to call you Y N

**OTHER/ CELL:**

Permission to call you Y N

Permission to leave message Y N

Permission to leave message Y N

Permission to leave message Y N

**Permission to use Mailing Address:** Y N **Special Instructions** \_\_\_\_\_

**Primary Insurance Information:** Insurance Company \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Co-pay Amount: \$ \_\_\_\_\_

Have you called Insurance for pre-authorization? Yes No Authorization # if required: \_\_\_\_\_

Name of Benefit Holder \_\_\_\_\_ Benefit Holder Birth Date: \_\_\_\_\_

Benefit Holder's Relationship to Client \_\_\_\_\_ Benefit Holder's SS# \_\_\_\_\_

**Secondary Insurance Information:** Insurance Company \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Co-pay Amount: \$ \_\_\_\_\_

Have you called Insurance for pre-authorization? Yes No Authorization # if required: \_\_\_\_\_

Name of Benefit Holder \_\_\_\_\_ Benefit Holder Birth Date: \_\_\_\_\_

Benefit Holder's Relationship to Client \_\_\_\_\_ Benefit Holder's SS# \_\_\_\_\_

Who referred you to me? \_\_\_\_\_

.....  
**For Office Use:**

**Copy of front and back of Insurance Card:** \_\_\_\_\_

**DSM Primary DX:** \_\_\_\_\_

## Fee Agreement

1. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. It is your responsibility to know any stipulations of your insurance such as co-pay amount, need for referral forms, deductibles, and need for treatment pre-authorization. For example, your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations otherwise you will be responsible for the payment. In addition, you will need to keep track of the number of sessions allowed; if this amount is exceeded you will be responsible for the payment.
2. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I prefer that all such work be done in your session so that you are fully aware of and can participate in what is written. If you give me the paperwork at the end of a session, I may not be able to complete it during the session, and I charge for paperwork that is done outside of sessions.
3. Please inform me immediately of any change in insurance coverage, employment, address, and phone numbers. Changes in insurance coverage could result in your sessions not being reimbursed by your insurance company, and then you would be responsible for the charges.
4. Co-payments, in the form of cash or check, are due at the beginning of each session. There is a \$25 charge for a returned check.
5. Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge you if you fail to show up for an appointment or if you cancel less than 24 hours before the appointment. You will be billed for the full cost of the session (\$80) since this charge cannot be billed to your insurance company.
6. If you are paying out of pocket, an initial session (lasting 1 hour) will cost \$100 and each follow-up session will cost \$80 (\$110 for couples and \$210 for couples extended session).
7. Other expenses:
  - a. For unpaid charges over 30 days old (from the date of the first billing), a service fee of 2% of the balance per month will be applied. A past due account may cause interruption of service.
  - b. \$25 for paperwork completed outside of a session
  - c. \$85 for a written report for any purpose (this fee must be paid before the report is released to you)
  - d. \$25 for a phone call lasting longer than 15 minutes

I have read the above information. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

---

Patient

Date

---

Therapist

Date

