A COUNSELING CENTER, P.C.: Intake Financial Form

CLIENT: Last Name | First Name | Middle Initial

M–F | married–divorced–never married–cohabitating

CLIENT: Date of Birth (m/d/y) | Sex | Marital Status

CLIENT: Social Security Number (SSN) | Axis I Primary Diagnosis (counselor provides)

CLIENT: Street | City | State | Zip

CLIENT: Home Phone | Work Phone | Insurance Phone

EMPLOYER OR NONE: Street | City | State | Zip

Client–Insurance–Parent | Same–Child–Spouse

BILL TO: | Relationship to Insured

Medicaid–FHC Options–Medicare–Champus–BC/BS–Other

INSURANCE | Policy # | Group #

INSURANCE: Street | City | State | Zip

I understand that if I either do not cancel an appointment 24-hours in advance or if I fail to show up for a scheduled appointment that I will be charged for that failed appointment.

Client/Parent/Guardian's Signature | Date Signed

AUTHORIZATION TO RELEASE INFORMATION

I/We hereby instruct and direct the above named insurance company to pay by check made out to and mailed to A Counseling Center, P.C. for any and all professional or medical care insurance benefits, either under basic insurance or major medical provisions, that are allowable, and/or to which I/We may be entitled to as a result of services rendered by A Counseling Center, P.C. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to A Counseling Center, P.C., and I have agreed to pay, in a current manner, any balance of said professional or medical service charges over and above my insurance payments unless such payments are prohibited by law. NOTE: If my current policy prohibits direct payment to a provider of services, I/We hereby further instruct and direct my insurance carrier to make the check out to me (the insured) and then to mail it to A Counseling Center, P.C., 3323 North 109th Plaza, Omaha, NE 68164-2908.

A photocopy or facsimile of this assignment and authorization shall be as effective and valid as the original.

Insured's Signature | Date | Client/Parent/Guardian's Signature | Date

I/We hereby authorize A Counseling Center, P.C. to initiate a complaint to the Insurance Commission on my behalf for any reason A Counseling Center, P.C. deems appropriate, necessary, or useful.

Insured's Signature | Date | Client/Parent/Guardian's Signature | Date

*****STOP***DO NOT WRITE IN THIS BOX / FOR OFFICE USE ONLY*****

Date of Confirmation of Benefits | Talked To

Street | City | State | Zip

Coverage Number | Deductible | Calendar Year Limit $ | Per Session $

Limitations | Notations

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