New Day Counseling

Client Information

Name:	Gender: M or F Birthdate:
Address:	City/State/Zip
Phone Home: Work: Cell:	

Insurance Carrier_____

Policy Holders Name: _____ Date of Birth: _____

Relationship to the Client: _____

Contract#_____ Group#_____

Insurance Phone# (back of card) _____

Secondary Insurance Carrier_____

Policy Holders Name: _____ Date of Birth: _____

Relationship to the Client: _____

Contract#_____ Group#_____

Insurance Phone# (back of card) _____

I give my authorization to release medical records to assist in the processing of my insurance claims. I also authorize payments of my Claims to be mailed directly to **New Day Counseling** for providing my services. I understand that I am completely responsible for any charges incurred and that billing my insurance does not guarantee payment of the claim(s). If the provider of service does not receive payment in a timely fashion, I understand that I may receive a bill for services rendered. I have also received a copy of the HIPAA policies and practices.

_____

Signature of Client Date

Office Use:
Diagnosis Code(s) _____ _____ _____ _____

Provider: