SUBURBAN CROSSROADS COUNSELING

for office use Authorization _____

Counselor _____

Dx 1 _____ Dx 2 _____

New Client Information

Name _____ Date of Birth _____

Gender _____ Relationship Status _____ SSN _____

Phone	*Preferred?*	*Message OK?*
Home _____	☐	☐
Work _____	☐	☐
Mobile _____	☐	☐

Email _____

Mailing Address

_____

_____

Please check: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Student ☐ Retired _____
Date of Retirement

Employer _____ Gross Income _____
For Sliding-scale, as needed

Emergency Contact

Name _____ Relationship _____

Phone *Primary* _____ *Other* _____

Insurance

*Primary Insurance*_____ Policy # _____ Group # _____

Policy Holder's Name _____

Date of Birth _____ SSN _____

Policy Holder's Employer _____

*Secondary Insurance*_____ Policy # _____ Group # _____

Policy Holder's Name _____

Date of Birth _____ SSN _____

Policy Holder's Employer _____

Payment You are responsible for the cost of all sessions. If you are using insurance, we will obtain payment from your insurance company on your behalf and you are responsible for all fees not covered by insurance. **PLEASE NOTE: appointments for which you have given less than 24 hours' cancellation incur a $60.00 fee.** In addition, there is a **$30.00** fee for bounced checks; and once a check bounces, we will only accept cash or money orders. For letters, reports, etc. there is a **$25.00** fee per half hour required. **These fees are NOT COVERED by insurance.**

Authorization I authorize Suburban Crossroads Counseling (SCC) to furnish information to my insurance carrier at the time of treatment concerning my diagnosis and treatments , and hereby assign to the provider all payments for medical services rendered to myself or my dependent (s). I understand I am responsible for payment as described in the above paragraph. This agreement will remain in effect unless revoked in writing.

Signature of Client/Guardian _____ _____ Date: _____