The Center for Healing
Indigo Wisdom Professional Counseling, LLC

Patient Demographic Information

Patient Name:	Social Security #:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Cell Phone:
Primary Physician:	Psychiatrist (if any):
Emergency Contact Person:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Insurance Information

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

Fees, Payment and Insurance Coverage

As the client, you are responsible for all of the service charges. Payment is expected at the time of your visit, unless previous arrangements have been made with your Clinician. If you are covered by insurance, you may only have to pay the portion of your bill that is not covered by insurance carrier at the time of your visit. However; you are still responsible for the full expense of the visit. Some insurance companies send payments directly to the insured. If you have not paid the full amount charged for your visits, it is your responsibility to bring or send in all insurance reimbursements that you receive within 5 working days. Delinquent accounts may be charged 15% annual interest, compounded monthly, and non-payment of bills may result in legal action and/or the use of professional collection services.

By signing below, I am acknowledging that I have read the preceding paragraph and agree to its provisions. I also attest that if treatment is for a minor, I am requesting treatment for a minor and that I am a parent or legal guardian legally authorized to give permission for such treatment to occur.

By signing below, I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Further; I authorize payment of medical benefits directly to The Center for Healing Indigo Wisdom Professional Counseling, LLC or supplier.

Client/Parent/Guardian Signature: _____

Date: _____