Judy Schrader, LMHC

Licensed Mental Health Counselor

CLIENT PERSONAL DATA AND CONSENT FORM

Client Information **Date: _____**

Last Name:_____First Name:_____MI:_____

Address: _____

City:_____State:_____Zip: _____

Birthplace: City/ State/ Country_____

Home Phone:_____Work Phone:_____Cell Phone:_____

(Please check best number to leave message)

Email: _____ Would you like reminder messages via email or text? Y N

Gender: (M/F) _____Date of Birth: _____ Social Security No: _____

Referred by: _____ Phone: _____

May I thank this individual for the referral? (Please Initial) Yes: _____ No: _____

Responsible Party Information (IF OTHER THAN CLIENT) **Relationship**: _____

Last Name:_____First Name:_____MI:_____

Address:_____

City:_____State:_____Zip:_____

Employer Information

Employer: _____ Phone: _____

Address: _____

City:_____State:_____Zip:_____

Emergency Contact Information

Name:_____ Relationship: _____ Phone:_____

Fee:

The fee ranges from $135 to $150 depending on the services provided or Insurance

Fee _____

I have received the Notice of Privacy Practices. _____ (please initial)

I have reviewed the Introduction to Psychotherapy and Financial Agreement information, and I voluntarily consent to participate in and be responsible for payment of psychotherapy services.

_____ _____ _____

Print name Signature of client or responsible party Date

Insurance Information **Judy Schrader, LMHC**

Please fill out the following information if you wish to use your insurance to pay for your therapy, and have verified with my office that I am a participating provider.

Name of Primary Insurance: _____ Phone: _____

Group Name or #: _____ Member ID #: _____

Policy Holder's Name (If Different from Client): _____

Address: _____

Insured Party ID #: _____ Birth Date: _____

Relation to Client: _____ Authorization #: _____

Do you have an EAP? No Yes

Do you have any other insurance? No Yes If yes, please notify the office manager.

Please read and sign the following.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Judy Schrader, LMHC. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the insurance claim form.

Signature: _____ Date: _____