Choices for Change Counseling, PC
Client Information Sheet

Adult Clients: **Please complete this form COMPLETELY**

Full Name_____Marital Status: Married Single Other

Age/Date of Birth_____ Sex: Male or Female

Home Address (City, State, Zip Code)_____

Phone #: Home (_____)_____Cell (_____)_____

Primary Care Physician_____Phone # (_____) _____

Have you received an assessment this year? YES (When/Where)_____NO___

Are you currently seeing a counselor? YES (Who)_____NO___

Primary Insured Insurance/Medicaid Information: **Please complete this form COMPLETELY**

Name of Insured_____

Age/Date of Birth_____ Marital Status: Married-Single-Other

Address, if different from above_____

Phone #: Home (_____) _____ Cell (_____) _____Work (_____) _____

Name of Employer _____ Group #_____

Insurance / Medicaid Name _____

****Please provide a copy of the front and the back of the primary and secondary insurance card(s).**

Member ID #_____ Customer Service Phone # (Back of Card)_____

Who is financially responsible for this bill? _____

Do you have secondary insurance coverage? Circle one: NO YES: _____

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Client's Name: _____

Release of Information for Insurance Verification/Authorization of Benefits/Claims Processing/Fee/Payment:

Please initial below:

1)____I authorize Ronnie McCarrell and its subsidiaries, to check/verify insurance coverage and benefits.
2)____I authorize the release of any medical or other information necessary to process claims related to services provided by Ronnie McCarrell.
3)____I authorize payment of medical benefits to Ronnie McCarrell for services provided.
4)____I understand and agree that I am financially responsible to pay for co-pay/coinsurance/deductible/other services not covered by my insurance and will be invoiced for payment when payment is not made.
5)____I authorize Ronnie McCarrell and his administrative staff to contact me via text message and email.
6)____I authorize Ronnie McCarrell to contact the following individual(s) for the sole purpose of scheduling appointments and/or for emergencies.

Contact Name: _____Number_____

Contact Name: _____Number_____

7)____ (If applicable) I authorize Ronnie McCarrell to release assessment information and/or recommendations to the referring agency/source.

Referral Source:
___Referred by:
Name-_____

Agency-_____

Contact Number-_____

For Adult Clients:

Signature: _____ Date _____

Print Name: _____

Email Address (If any)_____

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For Therapist only:
Preauthorization Required: Yes___ No___ Preauthorization Number: _____

Authorization Submitted: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

_____ _____

_____ _____