Choices for Change Counseling, PC
Client Information Sheet

<u>Minor Clients</u>: Please complete this form COMPLETELY

Full Name_____

Age/Date of Birth_____ Sex: Male or Female

Home Address (City, Zip Code)_____

Primary Care Physician_____Phone #: (_____) _____

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

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

Parent/Legal Guardian's Information:

Full Name_____

Home Address (if different from minor)_____

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

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

Name of Insured_____Date of Birth_____

SS#_____Marital Status: Married Single Other

Address, if different from above_____

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

Insurance Company/Medicaid Name _____ Member ID #_____

Group #_____ Customer Service Phone # (Back of Card)_____

Name of Employer _____ Who is financially responsible for this bill? _____

Do you have secondary insurance coverage? Circle one YES NO

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

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

Please initial below:

____I authorize Ronnie McCarrell and its subsidiaries, to check/verify insurance coverage and benefits.
____I authorize the release of any medical or other information necessary to process claims related to services provided by Ronnie McCarrell.
____I authorize payment of medical benefits to Ronnie McCarrell for services provided.
____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.
____I am authorized to enroll the minor client in counseling.
____I authorize Ronnie McCarrell and his administrative staff to contact me via text message and email.
____I authorize Ronnie McCarrell to contact and/or release information to the following listed individuals:

Contact Name: _____Number_____

Contact Name: _____Number_____

____I authorize Ronnie McCarrell to contact the following listed individuals for: appointments, emergencies, release of assessment information, and/or recommendations to the referring agency/source.

Referral Source:
___Self Referred
___Referred by:
Name-_____

Agency-_____

Contact Number-_____

For Minor Clients:

Minor's Signature: _____ Date _____

Parent's/Legal Guardian's Signature: _____ Date _____

Print Name/Relationship to Minor: _____

Email Address (If any)_____

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

Authorization Submitted: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

_____ _____

_____ _____