DLR Counseling Group

COUNSELING THAT MEETS YOU WHERE YOU ARE

DLR Counseling Group New Client and Insurance Information

Patient Information
First Name _____Middle ____ Last Name _____
Birth Date _____ Age _____ Sex _____ SS# _____
Home Phone _____ Work Phone _____
Street Address _____
City _____ State _____ Zip _____
Email Address _____
Can you be contacted and a message left at your _____
Employer _____
Employer Address _____

Individual Responsible for Payment
First Name _____Middle ___ Last Name _____
Birth Date _____ Age _____ Sex _____ SS# _____
Home Phone _____ Work Phone _____
Street Address _____
City _____ State _____ Zip _____
Email Address _____
Can you be contacted and a message left at your _____
Employer _____
Employer Address _____

Primary Insurance
Name of Insurance Company _____
Policy ID # _____
Group # _____
Street Address _____
City _____ State _____ Zip _____
Name of Policy Holder _____
Date of Birth _____ Relationship to Insured _____
Employer _____
Employer Address _____

Assignment of Benefits

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to DLR Counseling Group.

We must have your cooperation in obtaining necessary information. In the event that payments are not received in a timely manner or there is a collection problem you will be responsible for the insurance portion of your fees. It is your responsibility to notify our office of any changes in insurance coverage, as well as forward any insurance notices to our office.

I understand that there is a 24-hour cancellation policy, which requires that I cancel my appointment in advance to avoid the full charge of the session.

_____

Person Responsible for Payment Date