HEADWATERS COUNSELING

Client Information

Name: _____ **Date of Birth**: _____

Gender: ◉ M ○ F

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Name of Referring Physician or other source: _____

Insurance Carrier: _____

Policy Holder's Name: _____ **Date of Birth:** _____

Relationship to the Client: _____

Contract #: _____ **Group #:** _____

Insurance Phone # (back of card): _____

Secondary Insurance Carrier: _____

Policy Holder's Name: _____ **Date of Birth:** _____

Relationship to the Client: _____

Contract #: _____ **Group #:** _____

Insurance Phone # (back of card): _____

I give my authorization to release medical records to assist in the processing of my insurance claims. I also authorize payments of my Claims to be mailed directly to Headwaters Counseling, LLC for providing my services. I understand that I am completely responsible for any charges incurred and that billing my insurance does not guarantee payment of the claim(s). If the provider of service does not receive payment in a timely fashion, I understand that I may receive a bill for services rendered. I have also received a copy of the HIPAA policies and practices.

Signature of Client _____ **Date** _____

Office Use:

☐ **New Client** ☐ **Current Client – Information Update**

Diagnosis Code(s) _____

Provider Name: _____