Ellen Berk, LCSW, BCD

New Client Information

Date of First Visit:_____ **Dx. Code:**_____

Patient's Name:_____ **DOB:**_____ **Sex: Male**___ **Female**___

Address:_____
(Street) (City) (State) (Zip)

Phone: (home)_____ **Married** ___ **Single** ___ **Divorced** ___ **Separated** ___ **Widow(er)** ___

Cell_____ **(work)**_____ **Soc. Security#:**_____

Email:_____

Emergency Contact: _____ **Relationship:**_____ **Phone:**_____

Patient's Employer:_____ **Full-time** ___ **Part-time** ___

Employer's Address:_____
(Street) (City) (State) (Zip)

Student Status: Non-student ___ **Full-time** ___ **Part-time** ___

Relationship to Insured: Self ___ **Spouse** ___ **Child** ___ **Other Dependent** ___

Insured's Name:_____ **SSN#:**_____ **DOB:**_____

Insured's Address:_____ **Phone:**_____
(Street) (City) (State) (Zip)

Insurance ID/Claim #:_____ **Insured's Employer:**_____

Insurance:_____ **Phone:**_____
(Company Name)

Insurance Address:_____
(Street) (City) (State) (Zip)

Policy #:_____ **Group #:**_____ **Adjuster:**_____
(Name, if applicable)

Authorization# or Claim# (if applicable): _____

Secondary Insurance:_____ **Policy Holder:**_____
(Company Name)

Secondary Insurance Address:_____
(Street) (City) (State) (Zip)

Phone:_____ **Policy #:**_____ **Group #:**_____

Is Treatment: Work Related ___ **Auto Accident Related** ___ **(State where accident occurred** ____ **)**
Date of Injury:_____

We will be unable to bill your insurance for you unless you agree to the following terms by signing below:

I understand that I am fully responsible for, and agree to pay promptly all charges for services rendered, even if my insurance does not pay, unless my insurance's contract with the provider specifically relieves me of such responsibility. I also understand that I must pay full fee for telephone calls, and for appointments that I fail to keep or fail to cancel at least 24 hours in advance. (Insurance does not cover phone calls or missed appointments.) I agree that if I do not pay the amount owing, I will be responsible for all costs of collection which may include attorney's fees.

I authorize the billing of my insurance, and the release of any information necessary to process claims; and I authorize my insurance to pay directly to the provider medical benefits for services rendered.

My signature indicates that "I have read and understand my payment responsibility and release this information to insurance companies for payment purposes".

_____ _____

Patient /Insured's Signature Date Patient/Other Insured's Signature Date