Michael Noll, LPC

CLIENT INFORMATION

Date of Appointment ______________

Client ____ (M) ____ (F) ____
(First Name) (Middle Initial) (Last Name)

Birth Date ____________ Social Security Number ____________________________ Home Phone (____)________

Address ____ Cell Phone (____)________

City, State, Zip ____Work Phone (____)________

Spouse's Name _____________________________________ Mother's Name _______________________________
(Father, if minor) (If minor)

Foster/Step-Parent ____ Phone (____)________

Client's Employer _____________________________ Married___ Single___ Separated___ Divorced___ Widow(er)___

Referring Source/Primary Care Physician ____

Whom may we thank for referring you to us? ____

Send bill to: _________________________________ Phone (____)________

Address ____

Primary Insurance ____ Insured's Employer ___________________

Insured's Name ____ DOB ___________ SS# _____________

Insurance Phone # (____)________ Group # _____________________ Subscriber Id # ______________________

Secondary Insurance ____ Insured's Employer _________________

Insured's Name ____ DOB ___________ SS# _____________

Insurance Phone # (____)________ Group # _____________________ Subscriber Id # ______________________

INSURANCE REPORT AUTHORIZATION

I hereby authorize __ Michael Noll, LPC **_________ to release medical information to the above-named insurance company and/or HEALTH CARE FINANCING ADMINSTRATION AND ITS AGENTS, any information needed to determine insurance benefits or the benefits payable for related services. I authorize payment directly to the provider and request that payment of authorized MEDICARE benefits be made either to me, or on my behalf, to the provider. I understand and agree that I am responsible for any balance not paid by the insurance company. I have reviewed all of the above information and certify that this information is true and correct to the best of my knowledge. This authorization is in effect until I choose to revoke it.**

Client Signature ____ Date Signed: ____________________

Parent/Guardian Signature _______________________________________ Date Signed: ____________________

24 hr cancel notice__ 10-15 min. early for paperwork__ Call ins. Re p/a, co-pays, deductibles__ co-pays & deductibles due at time of service__ Cash Payment $________ due at time of service__ Location__ Sent Forms__ Ins. Checked by accounts manager__