Michael Noll Counseling

1477 Kenwood Dr, Suite 104
Menasha, WI 54952
http://michaelnollcounseling.com

(920) 215-1553 Phone/Text
(920) 821-1432 Fax
michael@michaelnollcounseling.com

CLIENT INFORMATION

Date of Appointment _____

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

Birth Date _____ Home Phone (____)_____Cell Phone (____)_____ Work Phone (____)_____

Address _____

City, State, Zip _____

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: _____ 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 Counseling, LLC**_____ 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__ Ins. Checked by accounts manager__