THE COUNSELING COLLABORATIVE

Milja Brecher-DeMuro, MSW, LCSW

Billing Intake Information

Date: _____

Client's Name: _____ DOB: _____
First/Last/Middle Initial mm/dd/yyyy

Mailing Address: _____

Physical Address (if different): _____

Phone Number: _____ Social Security #: _____
000-00-0000

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Seasonal ☐Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Primary Care Physician: _____ Phone Number: _____

INSURANCE INFORMATION:

Relationship to insured (policy holder) : ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Co-Pay Amount: $_____

COMPLETE IF RELATIONSHIP TO INSURED IS OTHER THAN "SELF":

Name of Insured (policy holder): _____
First/Last/Middle Initial

Address of Insured:_____
Street/PO Box Town, State, Zip

Phone # of Insured: _____ DOB of Insured:_____

Social Security # of Insured: _____

Employer of Insured: _____

Insurance Company: _____

Insurance Company Phone #: _____

Insured's ID#: _____ Group #: _____

Plan: _____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS:

I authorize the release of only necessary medical or other information required to process insurance claims. I also authorize payment of medical benefits to provider for services performed:

Client Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____