Your Safe Space, LLC

Client Demographic Form Please PRINT

Client Name:_____Nickname/AKA:_____

Birth date:_____ Age:_____ SSN:_____Sex/Gender ID:_____

Marital Status: Married_____ Single _____ Divorced _____ Separated_____ Widowed_____

Language spoken:_____ Race:_____ Ethinicity:_____Religion:_____

Home Address:_____

City: _____ State: _____ Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____
Preferred method of contact: (circle one) Phone Email Letter

Email address: _____ Employer: _____
Spouse/Parent: _____ Phone #:_____
Emergency Contact: _____ Phone #: _____

How did you hear about us: _____

INSURANCE INFORMATION

Ins Co Name: _____ Policy/ Member ID #:_____

Client Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Policy Holder: _____

Address: _____City: _____ Zip Code: _____

Home #:_____ Date of Birth: _____

Employer: _____

SECONDARY INSURANCE

Ins Co Name: _____ Policy/ Member ID #:_____

Client Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Policy Holder: _____

Address: _____ City: _____ Zip Code: _____

Home #: _____ Date of Birth: _____

Employer: _____

Therapy Sessions: We recommend that you call your insurance company to be informed of your benefits and or coverage for any services provided by Your Safe Space LLC for mental health/therapeutic services. You should inquire if pre-certification/authorization is needed. If so, it is recommended that you contact our office one week prior to your scheduled procedure to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our registrar to be copied. If we are unable to verify your insurance, you will be responsible for payment at the time of service. Your Safe Space participates with Medicaid and most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract.

- ❖ All co-payments, deductibles, and co-insurance as applicable are due at the time of service.
- ❖ Payment in full is due at the time of treatment/service for all private pay patients
- ❖ If coverage is contingent on a referral of pre-certification, it is your responsibility to inform us.
- ❖ If you are unable to keep your appointment, we require a 24 hour cancellation notice or your account **will be charged $30.**
- ❖ We accept cash, check, and the following credit cards: Visa and MasterCard. **Return checks are not handled in the office, they are handled by check processing company.**
- ❖ Any outstanding account turned over to a collection agency will be charged an **additional $35.00 fee.**

I hereby authorize Your Safe Space to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees, attorney fees, court costs, or other fees incurred by me.

_____ _____

Client/Responsible Party Signature Date

HIPAA NOTICE

I understand Your Safe Space, LLC is in compliance with the laws and guidelines of the HIPAA regulations. All services and records are confidential and private to protect the client.

_____ _____

Client Signature Date