CLIENT INFORMATION Clinician:_____ Date:_____

Name:_____(_____) **Birthdate:**_____**Age:**_____
LAST FIRST

Does client have a nickname/name preference?_____**Preferred gender pronoun?**_____

If client is a minor, provide names of parents/guardians. If client is an adult, skip to 'Address:'

Parent 1:_____(_____) **Parent 2:**_____(_____)
LAST FIRST LAST FIRST

Address: _____ **Address:**_____
PRIMARY ADDRESS WHERE BILL IS TO BE SENT ONLY IF PARENTS LIVE SEPARATELY

City: _____**Zip:** _____ **City:** _____ **Zip:**_____

CONTACT INFORMATION: We can send appointment reminders via text (TXT) or voice mail (VM).

PREFERRED CONTACT PHONE #: _____ TXT[ ] VM[ ] THIS PHONE BELONGS TO: _____

ALTERNATE PHONE # (optional): _____OK to LM? ____THIS PHONE BELONGS TO: _____

E-mail address:_____ **Referred By:** _____

FINANCIAL INFORMATION: Sliding Scale Fee:_____

Primary Insurance:

_____
Carrier **Policyholder** **Date of Birth**

_____
Contract or Member ID# **Group#** **Employer**

Address of Primary Insurance Member if Different from Above: _____

Secondary Insurance:

_____
Carrier **Policyholder** **Date of Birth**

_____
Contract or Member ID# **Group#** **Employer**

I CONSENT TO NECESSARY PRIVATE HEALTH INFORMATION BEING RELEASED TO THE ABOVE INSURANCE COMPANY(IES) FOR THE PURPOSE OF REIMBURSEMENT FOR SERVICES PROVIDED BY LITTLE HOUSE ON MACKINAW (DIANE KUKULIS, LMSW OR ERIN WERTH, LMSW). IF MY INSURANCE REJECTS PAYMENTS FOR ANY OR ALL OF MY TREATMENT I AM RESPONSIBLE FOR PAYMENT IN FULL. I AUTHORIZE LITTLE HOUSE ON MACKINAW TO RELEASE ALL NECESSARY INFORMATION TO MY INSURANCE COMPANY(IES) IN ORDER TO SECURE FINANCIAL PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE BELOW ON ALL INSURANCE SUBMISSIONS AND ASSIGN ALL MEDICAL BENEFITS TO LITTLE HOUSE ON MACKINAW. IF I FAIL TO KEEP MY SCHEDULED APPOINTMENT OR FAIL TO CANCEL APPOINTMENT WITHIN 24 HOURS PRIOR, I UNDERSTAND I MAY BE RESPONSIBLE FOR A CANCELLATION FEE OF $35.00. (NOTE: INSURANCE WILL NOT COVER MISSED APPOINTMENTS; SOME, BUT NOT ALL, INSURANCE CONTRACTS DISALLOW BILLING CLIENTS FOR MISSED APP'TS.)

_____
Signature of Client/Responsibility Party **Date**

VERIFICATION OF BENEFITS (FOR OFFICE USE ONLY):

_____

DX

Members of Household:

Name:	DOB:	Age:	Rx. to client:	Name of School w/ Grade or Place of Employment:

Emergency/Alternate Contact:

_____

Name **Phone #** **Relationship to client**

_____

Address **City** **ZIP**

Would you like me to send an assessment summary to another health care provider? **[ ] YES [ ] NO**
(Some insurance companies require that I provide a brief assessment in order to collaborate treatment)

Provider Name: _____Phone:_____Fax:_____

Provider Name: _____Phone:_____Fax:_____

School Information for Minor Client:

_____

Name of School City ZIP Phone Fax

Would you like me to send an assessment summary to the school? **[ ] YES [ ] NO**

Additional Information: _____