Barbara S. Kleinman, MSW, LICSW
Billing Information

Client's Last Name: _____ First Name: _____

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____Work #: _____Cell:_____ DOB:: _____

Emergency Contact and Telephone Number: _____

Gender: _____ Marital Status: _____Referred by: _____

Primary Care Physician:_____

Billing Information

Name of Responsible Party (if other than self): _____DOB_____
Address: _____ City: _____ Zip: _____
Phone: _____Relationship: _____Employer:_____

Insurance Information

Insurance I: _____ Co-pay Amount: _____
Insurance Mailing Address: _____

Subscriber Name: _____Relationship: _____DOB:_____

Certificate/ID#: _____ Group#: _____

Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____

Secondary Insurance

Insurance II: _____ Co-pay Amount: _____
Insurance Mailing Address: _____
Subscriber Name: _____Relationship: _____DOB:_____
Certificate/ID#: _____ Group#: _____
Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____

Clinician: Barbara Kleinman MSW Hourly Fee: $150.00 Initial Session / $120.00 Return Visit
Court fee: $200 per hour for preparation, reports, and court.

Is condition related to employment? _____ Auto Accident? _____ Other Accident? _____

I authorize the release of any medical/mental health information or personal information on this form to process this claim.

Signature: _____ Date: _____