**Redeeming Hearts LLC**
**Jack Venbrux, LCPC**
1103 W. Ironwood Dr.
Coeur d'Alene, ID 83814
Phone: (509) 536-5972
Email: jack@redeeminghearts.com

**CLIENT INFORMATION**

Last Name _____ First Name _____ Middle Name _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Mailing Address (*if Different*) _____

City _____ State _____ Zip _____ Email _____

Phone (Home) _____ (Work) _____ (Cell) _____

Employer/School _____

Date of Birth _____ Age _____

Sex: M F Marital Status: Single Married Other Spouse/Partner's Name _____

**FINANCIAL ARRANGEMENTS Cash/Check _____ Insurance _____ Both _____**

**Please Note: Payment for private pay clients and deductibles or co-payments for insurance clients is required at the time of service.**

**Primary Insurance Name** _____

Primary Insurance Provider Phone # _____

Subscriber # _____ Group # _____

Client's relationship to subscriber: Self___ Spouse ____ Child____ Other_____

*If Subscriber is not the client:*

Subscriber's Name _____

Subscriber Address: _____

Subscriber Birth Date _____ Subscriber Phone # _____

Subscriber Sex: M F Subscriber Employer _____

**Secondary Insurance Name** _____

Secondary Insurance Provider Phone # _____

Subscriber # _____ Group # _____

Client's relationship to subscriber: Self___ Spouse ____ Child____ Other_____

*If Subscriber is not the client:*

Subscriber's Name _____

Subscriber Address: _____

Subscriber Birth Date _____ Subscriber Phone # _____

Subscriber Sex: M F Subscriber Employer _____

**AUTHORIZATION AND FINANCIAL POLICY**

- To my knowledge, all of the above information is true.
- I hereby authorize Jack Venbrux, LCPC to provide counseling and/or treatment for myself and I accept responsibility for payment.
- I authorize this office to release to the named insurance company any CPT Billing code, Diagnosis, and Charge Amount as needed to process payment. I understand that I am responsible for all charges, regardless of insurance coverage.
- I understand that if my insurance company requires a doctor's referral or prior authorization it is my responsibility to be sure that these items are on file with my therapist.
- I understand that Jack Venbrux, LCPC requires, a 24 hour in advance, notification of appointment cancellation. Failure to call in advance and/or "no show" will result in a fee of $ 30.00, which will not be billed to my insurance company but will be my full responsibility.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to the initial office visit. I understand that Redeeming Hearts LLC only accepts checks or cash and at present does not do credit card billing. Any checks should be made out to "Redeeming Hearts".
- I authorize and request that insurance payments be made directly to Jack Venbrux, LCPC, Redeeming Hearts, LLC.

_____ _____

Client/Legal Guardian/Guarantor Signature Date

**WHO MAY WE THANK FOR YOUR REFERRAL**

- ☐ Doctor Please Identify _____
- ☐ Other Professional Please Identify _____
- ☐ Church Please Identify _____
- ☐ School Professional Please Identify _____
- ☐ Friend/Relative Please Identify (Optional)_____
- ☐ Web Search Engine & search phrase? _____
- ☐ Psychology Today Any search parameters?_____
- ☐ Other Please Identify _____