justheal COUNSELING

1400 Buford Hwy NE C1 l Sugar Hill Ga, 30518 l Phone (470) 326-5455
Send Completed PDF Form To Email: support@justhealcounseling.com
Appointments are usually granted within 2-4 business days

CLIENT: First Name:_____ **Last Name:** _____ **DOB**:_____

If minor, CAREGIVER/PARENT: First Name:_____ **Last Name:**_____

Street Address: _____ **City:** _____ **State: GA Zip:** _____

Primary Contact #:_____ **Secondary Contact #:**_____

Email Address: _____ **Therapy Sessions:** In-Office ☐ Tele-Health ☐

☐ **I Consent Permission for Just Heal Counseling to Contact via email to send PHI. I also understand that even with consent, emailing ePHI using an unencrypted email platform is taking a risk.**

Insurance Company Name _____ **Member's ID Number:** _____

PLAN CODE:_____ **Provider Relations 1-800 # on back of card:**_____

Name of the primary insurance holder (subscriber): _____ **DOB:**_____

Do you wish to use EAP? If so, who is the Program Administrator (if different from above): _____

Authorization #:_____ **# Sessions:**_____ **Effective Dates:**_____

Is your behavioral health benefit offered through a third-party provider. (ex. Optum, Health Advocate Solutions, etc)

Yes ☐ **No** ☐ **Name of Provider:**_____

Provider Services Contact Phone Number : _____

When submitting this form, please include a copy of the front and back of your insurance card. Thank you!

What brings you into Therapy? _____

Would You Like To Receive Monthly Newsletters? Yes Please ☐ No Thanks ☐

How or where did you hear about Just Heal?_____

Therapist Preferred: **Shamika B Packer** ☐ **Maggy Simpson** ☐ **Delancey Fortin** ☐ **Intern** ☐

FOR OFFICE USE ONLY:

Insurance Verified: ☐ **N/A: No Insurance/ Self-Pay**

Self-Pay Rate: _____ ☐ **Behavioral Health/Regular** ☐ **EAP** ☐ **FEP**

☐ **In-network Benefits:** ☐ **Out of Network benefits:**

Call Reference #:_____ **Agent:**_____ **Date verified:**_____