**Stacey J Nelson Ph.D. LMFT**  
    1200 N. Federal Highway Suite 200 Boca Raton FL 33432

(561) 859-7779   [drstacey@bellsouth.net](mailto:drstacey@bellsouth.net) website: [www.drstaceyjnelson.com](http://www.drstaceyjnelson.com)

**BILLING AND CORRESPONDENCE**

**P.O. Box 7052, Delray Beach FL 33482**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drivers Lic #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Partner’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#/ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone# For Mental Health Benefits\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Alcohol/Drug Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suicide Attempts\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

As a patient of Dr Stacey J Nelson’s a specific appointment time will be assigned to you. You will be financially responsible for that block of time; this time cannot be given to anyone else. Cancellation

notice of 24 hours is required to cancel without being charged for your time. Our office can file insurance claims as a courtesy for your direct reimbursement, once you have paid the office for services rendered by Stacey J Nelson Ph.D.. Dr Nelson is a participating provider with only a few insurance companies, and her practice is predominantly a fee for service practice. We do not accept credit or debit cards, without a $10 service charge. Payment for services rendered is expected to be paid on the day services are provided.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_understand that I am financially responsible for all fees for

Services rendered. If applicable, I authorize treatment for my minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_

I AGREE AND UNDERSTAND THAT IT IS THE POLICY OF Dr Stacey Nelson’s office to turn over all

Unpaid balances to a collection agency or attorney after a period of 60 days. I agree to pay any collection

Costs and/or attorney’s fees if my delinquent balance is placed with an agency or attorney for collection or suit.

By signing this financial consent you are acknowledging that you have read, understood and agreed to its terms

And are authorizing the office to release all necessary information to secure payment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Print Name Date

I have read the FLORIDA NOTICE Form (HIPAA) and understand my rights. Please initial \_\_\_\_\_