Maureen Tirella, LSW, LCADC

FAMILY CIRCLE COUNSELING, LLC

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DEMOGRAPHIC INFORMATION

Client name:	Date:	Ref by:

Cell phone:	Home phone:	Email:

Address:	City:	State:	Zip:

DOB:	SSN:	Employer:

Marital status: ○ Single ● Married ○ Partners ○ Union ○ Separated ○ Divorced ○ Widow ○ Unknown | Sex: ● F ○ M

PRIMARY INSURANCE INFORMATION

Name of insured:	Relationship to client:

Address:	DOB:	Employer:

Carrier:	Plan name:	Carrier phone:

Member ID:	Group Number:	Effective date:

Claims address:	Payor ID:	MC: ○ Y ○ N

Date verified:	Spoke with:	Call reference no.:

Co-pay:	Co-ins:	Covered at:	No sessions:	Deductible:	Met:	OOP Ind:	OOP Met:

Auth req:	Pre-cert req:	Auth or pre-cert info:

SECONDARY INSURANCE INFORMATION

Carrier:	Plan name:	Carrier phone:

Policy no:	Group no:	Effective date:

Claims address:	Payor ID:	MC: ○ Y ○ N

Date verified:	Spoke with:	Call reference no.:

EMERGENCY CONTACT

Name:	Relationship:	Phone:

CLIENT AGREEMENTS

I hereby grant authorization for insurance benefits to be paid directly to Maureen Tirella, LSW, LCADC and/or Family Circle Counseling, LLC and/or Best Practices BHOM, LLC for services rendered. Furthermore, I agree to be financially responsible for all charges incurred whether or not they are covered by my insurance. Additionally, I authorize the release of any and/or all information necessary to secure payment of benefits.

Client signature ____ Date ________________________

In order to cancel or reschedule an appointment you must call the office at least 24 hours in advance of your scheduled session. A fee of $50.00 will be assessed and due for any missed or cancelled appointment without proper notification. Your signature below indicates your understanding and acceptance of this policy.

Client signature ____ Date ________________________

PRACTICE INFORMATION

NPIT1: 1609435452 NPIT2: 1477070761 EIN: 81-2920449 License: 37LC00291900 PTAN: 641156 TIN: 20449