Roberta Gold, MSW, LCSW
FAMILY CIRCLE COUNSELING, LLC

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O: 848-219-1856 ▪ E: rgold.fcc@gmail.com **▪ F: 732-358-0829**

DEMOGRAPHIC INFORMATION

Client name:				Date:			Ref by:
Cell phone:		Home phone:			Email:		
Address:			City:		State:		Zip:
DOB:	SSN:		Employer:				
Marital status: ○ Single ● Married ○ Partners ○ Common Law ○ Separated ○ Divorced ○ Widow ○ Unknown							Sex: ● F ○M

PRIMARY INSURANCE INFORMATION

Name of insured:				Relationship to client:			
Address:			DOB:		SSN:		
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 Roberta Gold, MSW, LCSW 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: 1245515113 NPIT2: 1588021646 EIN: 45-3570352 License: 44SC05480900 PTAN: 239011 TIN: 70352