

**Karen L. Collier, LCSW**  
10641 Hillary Court, Suite 1  
Baton Rouge, LA 70810  
(225) 387-3325

### **INFORMED CONSENT CHECKLIST FOR TELEHEALTH SERVICES**

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Receipt of Notice of Privacy Practices**

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

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Signature of Patient or Authorized Party

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Date

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Witness

## CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby consent to diagnosis and treatment of myself by **Karen L. Collier, LCSW**. In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional person named above and not by Psychological Evaluation & Treatment Services.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone communications to third parties or yourself, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

- \* When you have filed a lawsuit placing your mental status at issue;
- \* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;
- \* When your condition poses a danger to yourself or someone else;
- \* When evidence of abuse is revealed.

Cancellation of sessions, and re-scheduling of sessions, must be done at least *24 hours* in advance. Answering service available *7 days a week, 24 hours a day*. If you do not cancel/reschedule at least *24 hours* in advance, you will be charged \$80. If you are going through an insurance company, you should know that they will **not** pay this cancellation fee; it will be an out-of-pocket expense for you.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

**Karen L. Collier, LCSW**  
*Client Information*

**\*\*Please fill out entire form to the best of your ability\*\***

**Patient Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **Age** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Mailing Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip code** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_ **SSN#** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Email Address** \_\_\_\_\_

**Employer/Occupation** \_\_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_

**Highest Grade Completed or Degree** \_\_\_\_\_ **School** \_\_\_\_\_

**Marital Status** Single \_\_\_\_ / Married \_\_\_\_ (Date \_\_\_\_\_) / Widowed \_\_\_\_ (Date \_\_\_\_\_)  
Separated \_\_\_\_ (Date \_\_\_\_\_) / Divorced \_\_\_\_ (Date \_\_\_\_\_)

**Spouse Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Age** \_\_\_\_\_

**Address (if different)** \_\_\_\_\_

**Telephone** (\_\_\_\_) \_\_\_\_\_ **SSN#** \_\_\_\_-\_\_\_\_-\_\_\_\_\_ **Cell Phone** (\_\_\_\_) \_\_\_\_\_

**Employer/Occupation** \_\_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_

**Children (names and ages)** \_\_\_\_\_

\_\_\_\_\_

**Parents** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Telephone** (\_\_\_\_) \_\_\_\_\_

**Brothers/Sisters (names and ages)** \_\_\_\_\_

\_\_\_\_\_

**Chief Complaint** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous Evaluation/Treatment (where, when, who)** \_\_\_\_\_

\_\_\_\_\_

**Medications (Current/Past)** \_\_\_\_\_

\_\_\_\_\_

**Referred by** \_\_\_\_\_

## ADULT SYMPTOM CHECKLIST

In order to assist your clinician in the assessment process, please check any of the following symptoms that you have experienced within the last month.

- |                                                         |                                                         |
|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Irritability                   | <input type="checkbox"/> Frequent sadness               |
| <input type="checkbox"/> Sleep problems                 | <input type="checkbox"/> Recent loss                    |
| <input type="checkbox"/> Worry a lot                    | <input type="checkbox"/> Parenting problems             |
| <input type="checkbox"/> Tense                          | <input type="checkbox"/> Marital problems               |
| <input type="checkbox"/> Nightmares                     | <input type="checkbox"/> Sexual problems                |
| <input type="checkbox"/> Poor appetite                  | <input type="checkbox"/> Family problems                |
| <input type="checkbox"/> Excessive appetite             | <input type="checkbox"/> Work or school problems        |
| <input type="checkbox"/> Binge eating                   | <input type="checkbox"/> Hearing voices                 |
| <input type="checkbox"/> Weight loss                    | <input type="checkbox"/> Do things over and over        |
| <input type="checkbox"/> Crying                         | <input type="checkbox"/> Trouble making decisions       |
| <input type="checkbox"/> Poor concentration             | <input type="checkbox"/> Drug usage                     |
| <input type="checkbox"/> Low energy                     | <input type="checkbox"/> Drink too much                 |
| <input type="checkbox"/> Energy loss                    | <input type="checkbox"/> Family members drink           |
| <input type="checkbox"/> Hopelessness                   | <input type="checkbox"/> Overspending                   |
| <input type="checkbox"/> Fearfulness                    | <input type="checkbox"/> Gambling                       |
| <input type="checkbox"/> Lying                          | <input type="checkbox"/> Jealousy                       |
| <input type="checkbox"/> Shyness                        | <input type="checkbox"/> Hurts self                     |
| <input type="checkbox"/> Vomiting after eating          | <input type="checkbox"/> Trouble with law               |
| <input type="checkbox"/> Laxative use to control weight | <input type="checkbox"/> Memory problems                |
| <input type="checkbox"/> Trouble expressing feelings    | <input type="checkbox"/> Feel someone is out to get you |
| <input type="checkbox"/> Trouble managing anger         | <input type="checkbox"/> Feel taken advantage of        |
| <input type="checkbox"/> Physical violence              | <input type="checkbox"/> Fears of _____                 |

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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Authorization for Release of Confidential Information  
**Part I**

I, \_\_\_\_\_, give my consent for the  
release of confidential information concerning:

myself

Information to be released is limited to:

all findings

Disclosure of this information is for the purpose of:

evaluation or treatment

Information shall be exchanged between:

Karen L. Collier, LCSW

***And the following person(s): (Ex: parent/guardian, spouse, primary care physician, etc.)***

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

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

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**Authorization for Release of Confidential Information**  
**Part II**

I, \_\_\_\_\_, give my consent for the  
release of confidential information concerning:

myself

Information to be released is limited to:

my findings

Disclosure of this information is for the purpose of:

evaluation or treatment

Information shall be interchanged between:

Karen L. Collier, LCSW

and:

YOUR INSURANCE PROVIDER

This consent may be revoked in writing at any time, but such revocation shall not  
be retroactive. This consent shall expire not later than one year after treatment  
ends.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

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### **Insurance Filing Requirements**

Our current office policy requires payment at the time of service. We will file with all in-network managed care companies if indicated below. If you do not wish for us to file with your in-network insurance company, we will not backdate services if you later decide you want us to file. However, we will start filing your claims starting on the date you sign a new 'Insurance Filing Requirements' form allowing us to do so. If you have out-of-network insurance, we will not file for you but you are allowed to file on your own. Please note that insurance companies have limitations on which diagnoses and services are covered, and this information may be used in determining future insurance eligibility. **This means you are responsible for any payments not covered under your insurance policy.** Refer to your policy for these details.

- ☐ I do want this office to file with my in-network insurance company at this time
- ☐ I do not want this office to file with my in-network insurance company at this time
- ☐ I do not have health insurance at this time

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Signature of Authorized Party

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Date

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Witness



Please sign, date, and sign.

Do not fill out the rest.

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

|                                                                                                                                                                                                                                                                                          |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|-----------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|-----------------------------------|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|
| PICA <input type="checkbox"/>                                                                                                                                                                                                                                                            |  |  |  |  |                                   |  |  |  |  | PICA <input type="checkbox"/>                                                                                                                                  |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>              |  |  |  |  |                                   |  |  |  |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                                                |  |  |  |  |                                   |  |  |  |  | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>                                                                     |  |  |  |  |  |  |  |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)                                                                               |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)                                                                                                                                                                                                                                                       |  |  |  |  |                                   |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 7. INSURED'S ADDRESS (No., Street)                                                                                                      |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| CITY                                                                                                                                                                                                                                                                                     |  |  |  |  | STATE                             |  |  |  |  | 8. RESERVED FOR NUCC USE                                                                                                                                       |  |  |  |  |  |  |  |  |  | CITY                                                                                                                                    |  |  |  |  | STATE                             |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| ZIP CODE                                                                                                                                                                                                                                                                                 |  |  |  |  | TELEPHONE (Include Area Code) ( ) |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  | ZIP CODE                                                                                                                                |  |  |  |  | TELEPHONE (Include Area Code) ( ) |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                                          |  |  |  |  |                                   |  |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:                                                                                                                         |  |  |  |  |  |  |  |  |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER                                                                                               |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER                                                                                                                                                                                                                                                |  |  |  |  |                                   |  |  |  |  | a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  |  |  |  |  |  |  |  |  | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>                                           |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| b. RESERVED FOR NUCC USE                                                                                                                                                                                                                                                                 |  |  |  |  |                                   |  |  |  |  | b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____                                                                 |  |  |  |  |  |  |  |  |  | b. OTHER CLAIM ID (Designated by NUCC)                                                                                                  |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| c. RESERVED FOR NUCC USE                                                                                                                                                                                                                                                                 |  |  |  |  |                                   |  |  |  |  | c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                    |  |  |  |  |  |  |  |  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME                                                                                                  |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME                                                                                                                                                                                                                                                   |  |  |  |  |                                   |  |  |  |  | 10d. CLAIM CODES (Designated by NUCC)                                                                                                                          |  |  |  |  |  |  |  |  |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d. |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.                                 |  |  |  |  |                                   |  |  |  |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| SIGNED _____                                                                                                                                                                                                                                                                             |  |  |  |  |                                   |  |  |  |  | DATE _____                                                                                                                                                     |  |  |  |  |  |  |  |  |  | SIGNED _____                                                                                                                            |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____                                                                                                                                                                                                             |  |  |  |  |                                   |  |  |  |  | 15. OTHER DATE MM DD YY QUAL. _____                                                                                                                            |  |  |  |  |  |  |  |  |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY                                                        |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                                                                                                                                                                                                                           |  |  |  |  |                                   |  |  |  |  | 17a. _____                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                                    |  |  |  |  |                                   |  |  |  |  | 17b. NPI _____                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____                                              |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____                                                                                                                                                                                       |  |  |  |  |                                   |  |  |  |  | 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| A. _____ B. _____ C. _____ D. _____                                                                                                                                                                                                                                                      |  |  |  |  |                                   |  |  |  |  | 23. PRIOR AUTHORIZATION NUMBER _____                                                                                                                           |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| E. _____ F. _____ G. _____ H. _____                                                                                                                                                                                                                                                      |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| I. _____ J. _____ K. _____ L. _____                                                                                                                                                                                                                                                      |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 1                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 2                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 3                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 4                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 5                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 6                                                                                                                                                                                                                                                                                        |  |  |  |  |                                   |  |  |  |  |                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                         |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                    |  |  |  |  |                                   |  |  |  |  | 26. PATIENT'S ACCOUNT NO.                                                                                                                                      |  |  |  |  |  |  |  |  |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |                                   |  |  |  |  | 28. TOTAL CHARGE \$ |  |  |  |  |  |  |  |  |  | 29. AMOUNT PAID \$ |  |  |  |  |  |  |  |  |  | 30. Rsvd for NUCC Use |  |  |  |  |  |  |  |  |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)                                                                                                                   |  |  |  |  |                                   |  |  |  |  | 32. SERVICE FACILITY LOCATION INFORMATION                                                                                                                      |  |  |  |  |  |  |  |  |  | 33. BILLING PROVIDER INFO & PH # ( )                                                                                                    |  |  |  |  |                                   |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| SIGNED _____                                                                                                                                                                                                                                                                             |  |  |  |  |                                   |  |  |  |  | DATE _____                                                                                                                                                     |  |  |  |  |  |  |  |  |  | a. NPI                                                                                                                                  |  |  |  |  |                                   |  |  |  |  | b. NPI              |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |