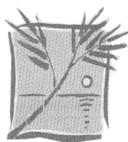
Healing Concepts, LLC
Paul C. Briggs, LCSW, LICSW, LMT, SEP, BC-TMH
Florida: SW5478, MA34970 • North Carolina: C003436 •
Massachusetts: 110348



P. O. Box 849257
Pembroke Pines, Florida 33084-1257
E-mail: healingconcepts@bellsouth.net
Web: www.HealingConcepts.org
Phone: 305.310.4591

Financial and Insurance Information

Patient Information

Today's Date ______________________

Name ____ Preferred Name ____________________________________

DOB __________________ Gender ____________________________ Preferred Pronouns ______________________________

Address ____________________________________City___________________________State__________Zip____________

Marital status __________ Social Security # _________________________ E-mail ____________________________________

Phone # - home ___________________________ cell ___________________________ business _________________________

Employer ____ Occupation _______________________________

Address ____

Physician's name ____ Phone # __________________________________

Emergency contact name ____ Phone # ________________________________

Financially Responsible Person

☐ check if same as above

Name ____ Social Security # ______________________ DOB _______________

Address ____Phone # - home ____________________ cell ___________________

Employer ____ Occupation ______________________________

Address ____

Primary Insurance Information (This information is required)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Employer ☐ Other: ___________________________________

Insurance Company: ____ Name of Insured _____________________________

Insured's Date of Birth ___________________ Social Security # _________________________ Gender ____________________

Policy# ____ Group# ____

Secondary Insurance Information (This information is required)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Employer ☐ Other: ___________________________________

Insurance Company: ____ Name of Insured ____________________________

Insured's Date of Birth ___________________ Social Security # __________________________ Gender ___________________

Policy# ____ Group# ____

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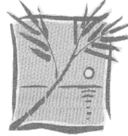

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Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim.

I hereby authorize my insurance carrier to pay and assign all medical and/or mental health benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Employee assistance Programs and other health plans to Healing Concepts, LLC or Paul C. Briggs, LCSW, LICSW, LMT. I authorize the release of any medical records for treatment, payment or healthcare operations.

Insurance is not a guarantee of payment for any claim, further I understand that I am financially responsible for all charges incurred regardless of insurance coverage.

Authorized Signature ____ Date _______________________

All copays, co-insurances and deductibles must be paid at the time of service _______________ (initial)

There is a $120.00 charge for missed appointments without a 24 hour cancellation, which cannot be billed to your insurance ________________ (initial)

PLEASE INCLUDE COPIES (FRONT AND BACK) OF A PHOTO ID AND YOUR CURRENT INSURANCE CARD IN THE SPACE BELOW OR ON AN ADDITIONAL PAGE