Linganore Counseling and Wellness, LLC

Patient Information

INSURANCE PLAN NAME	PLACE OF EMPLOYMENT ASSOCIATED W/INSURANCE		INSURANCE MEMBER ID NUMBER
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	PATIENT'S DATE OF BIRTH MM | DD | YYYY | |	SEX ☐ M ☐ F	INSURED'S NAME (LAST, FIRST, MIDDLE INITIAL)
PATIENT'S ADDRESS (NO, STREET)	PATIENT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		INSURED'S ADDRESS (NO, STREET)
CITY/STATE | ZIP	PATIENT STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER		CITY/ STATE | ZIP
PREFERRED PHONE # ☐ CELL ☐ HOME ☐ OFFICE	NAME ASSOCIATED W/ THE PREFERRED PHONE #		RENEWAL PERIOD OF PRIMARY INSURANCE
SECONDARY PHONE # ☐ CELL ☐ HOME ☐ OFFICE	NAME ASSOCIATED W/ THE SECONDARY PHONE #		IS THERE ANOTHER HEALTH BENEFIT (SECONDARY INSURANCE) ☐ YES ☐ NO
EMAIL ADDRESS			SECONDARY INSURANCE PLAN NAME (IF APPLICABLE)
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #		SECONDARY INSURANCE ID NUMBER
PRIMARY PHYSICIAN NAME	LOCATION OF PRIMARY PHYSCIAN		NPI # (OFFICE USE)
EAP NAME (IF APPLICABLE)	EAP AUTH (IF APPLICABLE)		NUMBER OF EAP SESSIONS (IF APPLICABLE)
PATIENT'S OR AUTHORIZED PERSONS SIGNATURE to release any medical or other information necessary to process this claim. SIGNATURE:			DATE

✧✧

CREDIT CARD PAYMENT AUTHORIZATION FORM

I agree to allow Linganore Counseling and Wellness, LLC to charge current and future invoice balances to this credit card. I understand that claims will be first sent to my health insurance, but that I am responsible for any unpaid claims. I have read and understand Linganore Counseling and Wellness, LLC's fees for service and cancellation policy. I agree to have any unpaid fees charged to the credit card listed below.

Account Type: ☐ *Visa* ☐ *Master Card*

Cardholder Name ____

Account Number ______________________________ *Exp Date* ____________

______________________________ ____________

SIGNATURE ______________________________ *DATE* ____________