|  |  |
| --- | --- |
| Today’s Date  | Rendering Provider: Allison Grace, MSW, LCSW  |

### PATIENT INFORMATION

|  |  |
| --- | --- |
| Client’s Name: (first/last) | Parent/Guardian: |
| Phone Number:  | DOB: Gender: M or F |
| Street Address: | City/State/Zip: |
| Emergency Contact:  | Phone: | Relationship to client:  |
| Reason for visit: | Previous diagnosis:  |
| Primary Care Physician: | Primary Care Physician Contact: |

### INSURANCE INFORMATION

**Primary insurance: \_\_New Insurance \_\_ Old Insurance \_\_Termed Date \_\_ /\_\_/\_\_**

|  |  |
| --- | --- |
| Subscriber’s name: |  Birth date: |
| Subscriber’s S.S. no.: | Policy no: | Group No: |
| Subscriber’s Address: |  |
| Employer: |
| Client’s relationship to subscriber:  |

**Secondary insurance:**

|  |  |
| --- | --- |
| Subscriber’s name: |  Birth date: |
| Subscriber’s S.S. no.: | Policy no: | Group No: |
| Subscriber’s Address: |  |
| Employer:  |  |
| Patient’s relationship to subscriber:  |

**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD**

|  |  |
| --- | --- |
| Financially Responsible Name: | Phone Number: |
| Address: |  |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Microsoft** or insurance company to release any information required to process my claims

|  |  |
| --- | --- |
| Patient/Guardian signature | Date |

I understand that everything I discuss with Allison Grace, MSWLCSW in Psychotherapy is confidential and protected by HIPAA. The only exception to this could be if I share life threatening information or cases of child or elder abuse/neglect.

I understand that I will be charged for:

• Canceling an appointment without 24 hours’ notice. ($45)

• Phone consults that last longer than 15 minutes. ($2 per minute)

• Denial of coverage from my insurance company.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Guarantee

( ) Uninsured Clients

Clients who are uninsured or whose insurance does not cover Mental Health Counseling Benefits due to high deductibles or other limitations are personally responsible for payment. Any balance not paid after 90 days of invoicing will automatically be charged to your designated card below.

( ) Insurance Assignment

My Insurance Assignment Program is designed to keep you out-of-pocket expenses to a minimum. As a courtesy to you My billing company, Missing Piece Billing will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember however, that you are ultimately responsible for payment. On day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims will be immediately refunded to you.

I agree to the above term and authorize Awaken Grace LLC or Missing Piece Billing Co. to charge any payment not paid by the end of the 90 day cycle.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you would like for this card to be used as a convenience courtesy for your copays which are due at the time of service, please sign below? If not, leave blank.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature below indicates that you have received a copy of the CONSENT TO PSYCHOTHERAPY Agreement and the **Notice of Privacy Practices** and agree to their terms. You understand that if at any time you have questions about these terms we can discuss to your satisfaction.

 **Signature** of Patient or Personal Representative

 **Printed** Name of Patient or Personal Representative

 Date

Description of Personal Representative’s Authority:

Please complete and return to Allison Grace at least 48 hours before your first visit if you would like to use your insurance to pay for these services.

Send to Awaken.grace@gmail.com, or fax to 855-744-8767, or text to 314-578-3551