Billing and Insurance Information

Client Information

Last Name _____First Name _____Middle Initial _____

Date of birth _____ Age_____ Gender _____ Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other (please describe)_____

Student: School/University _____ Level (grade/degree/year) _____

_____

Client Address City State Zip Code

Cell Phone _____ Work Phone _____ Home Phone _____

Email Address _____How did you learn of my practice? _____

Employment Information

Status: ☐ Employed, full-time ☐ Employed, part-time ☐ Student, Full-time ☐ Student, Part-time ☐ Other _____

Employer Name _____ Employer Phone _____

_____

Employer Address City State Zip Code

Primary Insurance

Insurance Company _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

_____

Policy Holder Address City State Zip Code

Subscriber ID _____ Group Number _____ Plan name/number _____

Policy Holder Employer _____

Secondary Insurance (if applicable)

Insurance Company _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

_____

Policy Holder Address City State Zip Code

Subscriber ID _____ Group Number _____ Plan name/number _____

Policy Holder Employer _____

FINANCIAL AGREEMENT

I, the undersigned, agree to pay in full, at the time of service, for all services rendered if DEBRA S. UNGER, LCSW, ACSW is not contracted with my insurance company or network. In the event that DEBRA S. UNGER, LCSW, ACSW is participating with my insurance company or network, I agree to pay all applicable co-pays, deductibles, and/or coinsurance amounts at the time of service. I acknowledge and understand that services provided at this office will be non-Medicaid/Medicare, Tricare, and ICHIA reimbursable, and I agree not to utilize those benefits and assume full financial responsibility for all services rendered. I understand that 24 hours notice of cancellation is required to avoid charges for missed appointments. I further understand that in families where parents do not share the same household, payment for services is the responsibility of the parent who accompanies the child to the appointment. I agree to provide accurate and updated insurance information to assist in my financial reimbursement from insurance for services provided. I authorize the release of any information acquired in the course of treatment necessary to process an insurance claim, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Client Signature _____Date_____

Parent/Legal Guardian Signature (if client is a minor) _____

Relationship to Client _____Date _____

PRIVACY ACKNOWLEDGEMENT

I, the undersigned, hereby acknowledge that I have received a copy of the 'Notice of Privacy Policies' to review. I understand that this notice describes how my information may be used and disclosed, and how I may access this information. I am aware that I can direct further questions about confidentiality to DEBRA S. UNGER, LCSW, ACSW.

Client Signature _____Date_____

Parent/Legal Guardian Signature (if client is a minor) _____

Relationship to Client _____Date _____

CONSENT TO USE EMAIL COMMUNICATION

I, the undersigned, hereby agree to sending to and receiving from DEBRA S. UNGER, LCSW, ACSW email communications as part of comprehensive treatment for me or my child. I understand the risks of sending PHI through email, and with this agreement I am accepting these risks. I accept that DEBRA S. UNGER, LCSW, ACSW shall not be held responsible for any exposure of email communications. I also understand that email communications can fail in their transmission, and I agree to contact DEBRA S. UNGER, LCSW, ACSW if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing DEBRA S. UNGER, LCSW, ACSW in writing. I agree that the benefits of using email communications for my health or my child's health care outweigh the security risks.

Client Signature _____Date_____

Parent/Legal Guardian Signature (if client is a minor) _____

Relationship to Client _____Date _____