REFLECTIONS PROFESSIONAL COUNSELING, LLC

CLIENT INFORMATION AND RELEASE

Client Name: _____ Age: ____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone (home): _____(work): _____Gender: (M/F): _____ Marital Status: ___
Social Sec. # _____-___-_____ Referred by: _____

Information Regarding the Insured

Name of Insured: _____ Relationship: _____
Date of Birth (of insured): _____ Phone #: _____ Gender: _____ Marital Status: ____
Employed: Full-time ___ Part-time___ Employer: _____
Insurance Co. Name: _____ ID #: _____ Grp# _____
Insurance Co. Address (city/state/zip): _____
Insurance Co. Phone Number: _____

Secondary Insurance (#2)

Name of Insured: _____ Relationship: _____
Insurance Co. Name: _____ **Insurance Co. Phone #:** _____
Insur. Co. Address (city/state/zip): _____
I.D. #: _____ Group #: _____

Release and Assignment

I hereby authorize release of any information necessary included protected health information to process insurance claims. Client has the right to review Notice of Privacy Practices before signing this consent. Client has the right to restrict how information will be used or disclosed for treatment, payment, or health care operation. Client has the right to revoke the consent in writing except to the extent that Andrea Stickel LPC has taken actions in reliance on previously signed consent.

I further authorize Andrea Stickel LPC to bill my insurance company for payment and assign and request that said payments be sent to her. In the even that my insurance company should send me the payments that are due Andrea Stickel LLPC, I will forward said payments to her without delay. Any services not covered by insurance I agree to pay in full at time of appointment.
Patient (or Guardian) Signature: _____ Date Signed: _____

I acknowledge receipt of Andrea Stickel LPC's Notice of Privacy Practices _____ (initial)
Office Use Only:
Initial DOS: _____Diagnosis: _____ Authorization: _____