Kendra McCallie LIMHP, LCSW
PSYCHOTHERAPY AND THERAPEUTIC YOGA

CLIENT INFORMATION

Today's Date:_____

Name of Client:_____

Date of Birth:_____ Age:_____ SSN#_____

Address:_____ City:_____State:_____Zip:_____

Phone: Home:_____ Work:_____ Cell:_____

Single____ Married___ Separated____ Divorced____ Widow(er)____ Child under 19____

Primary Occupation:_____Employer/School_____

Current Living Situation: Alone_____ With Parents_____ With Spouse/Partner/Children_____

Emergency Contact:_____phone: home:_____cell:_____
(I agree for this person to be contacted in an emergency (initial)_____

Referred By: _____

Insurance Information:
Name of Primary Insurance:_____Member ID#_____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Name of Secondary Insurance:_____Member ID#_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Responsible Party for Billing:_____

Authorization # for Primary Insurance:_____ Secondary Auth #_____

Copay:_____ Coinsurance:_____ Deductible:_____ Deductible Met:_____

Assignment of Insurance Benefits
The undersigned hereby authorizes the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Kendra McCallie to submit claims for insurance benefits, for services rendered, or for services to be rendered, without obtaining my signature to each and every claim submitted for myself/dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I therefore authorize my insurance company to pay and hereby assign directly to Kendra McCallie, LIMHP, LCSW all insurance benefits, if any otherwise payable to me for services described on the attached forms. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I further acknowledge that any insurance benefits, when received by and paid to Kendra McCallie will be credited to my account, in accordance with the above said assignment. I understand that Kendra McCallie may use and disclose the client's health information to obtain payment for services provided. I also understand that should the client account balance remain outstanding that Kendra McCallie does utilize services of a collection agency.

Client (or Legal Guardian):_____Date:_____

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