Entered in the computer for tracking _____

OSTERMILLER COUNSELING SERVICES, INC.

Client and Insurance Information

Client Information

Date: _______________ Who referred you to our office? _______________________________

Patient's name: ____ Date of birth: ____________________________

Address: ____City: _____________________ State: _____________ Zip: _______________

Phone: H: _______________________ W: _____________________ C: __________________________ Email: ____________________________

Marital Status: _________ Student? Y N School: _________________________________

Employer: ____ Phone: _____________________________

Spouse: _______________________________ _Spouse's employer: _________________________________ Phone: ______________________

Custodial parent (if minor): ___________________________ Parent's employer: _________________________ Phone: _____________________

Name of person responsible for payment: ____ Phone: ____________________________

Address: ____City: _______________________ State: ______________ Zip: _____________

Insurance Information

Have you phoned your insurance company to request pre-authorization of services? **Y or N / Authorization #** ______________________

Primary Insurance Co: ___________________________ Address: ____ Zip: __________________

Employer: ____________________________ Address of employer: ____ Zip: _______________

Policy holder's name: _______________________________ Enrollee ID ________________________________ Policy or Group #____________

Policy holder's: Date of birth: ___________________ SS#: _________________________________ Phone: ______________________

Address of policy holder: ____ Zip: _________________

Secondary Insurance Co: _______________________________ Address: ____ Zip: ___________

Employer: ____________________________ Address of employer: ____ Zip: ______________

Policy holder's name: ___________________________ Enrollee ID#: _____________________________ Policy or Group # _________________

Policy holder's: Date of birth: _____________________ SS# ________________________________ Phone: _______________________

Address of policy holder: ____ Zip: ____________________

Release of Information and Assignment of Insurance Benefits

I authorize Ostermiller Counseling Services, Inc. to evaluate and treat my condition. I also authorize Ostermiller Counseling Services, Inc. to disclose portions of my clinical record to my insurance company and/or its contracted review agent for reimbursement of services. I release Ostermiller Counseling Services, Inc. from all liability that may arise as a result of disclosure of this information to the insurance company.

In consideration of services rendered for the above-named client, I assign to Ostermiller Counseling Services, Inc., all professional expense benefits payable to the above policies. You are responsible for paying the portion not covered by your insurance.

X ____ __________________

*** Signature of Insured (or legal guardian if minor)** **Date**