Marie Murad-Feldman M.A., LCPC

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Chicago, IL. 60614-1010

Client Insurance Information / Payment Authorization

(Please Print) Today's Date: _____/_____/_____

Client's full name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Sex: _____ Age: ____ DOB: _____/_____/_____

Client Employer: _____ Work#: ( ) _____

Physician: _____ Referred By: _____

Person to Contact in Emergency: _____ Phone: ( ) _____

INSURED / RESPONSIBLE PARTY INFORMATION

Full name of Insured: _____ Relationship: _____

Home Address: _____ Phone: ( ) _____

Employer Address: _____ Phone: ( ) _____

Insured's SS#: _____

Primary Ins. Co.: _____ I.D. #: _____ Group #: _____

Secondary Ins. Co. ____ NO ____ YES Company: _____ Policy #: _____

Job Related Injury – Workmen's Comp.: ____ No ____ yes Company: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.

2. I authorize the release of information to my insurance company (s).

3. I understand that I am responsible for payment of the full amount of my bill for services provided.

4. I authorize direct payment to my service provider.

5. I hereby permit a copy of this to be used in place of an original.

6. I have been given a copy of this authorization for my records.

Client Name: _____ I.D. # _____

Client Signature: _____ Date: _____/_____/_____

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided. There will be a $30.00 service charge on all returned checks. In the event your account goes to collections, there will be a 20% collection fee added to your balance. There is a 24-hour cancellation policy which requires that you cancel your appointment 24 hours in advance or a $50.00 fee will apply.

Client Signature: _____ Date: _____/_____/_____

Clinician's Signature/Credentials: _____ Date: _____/_____/_____