North Gwinnett Counseling Associates, LLC
3455-A Lawrenceville-Suwanee Rd. Suwanee, GA 30024 – 770-932-2899

Client Demographic and Billing Information Form

Client Information

Client Name: _____ DOB: _____

Client Address: _____

City/State/Zip: _____ Home Phone: _____

Email: _____ Cell Phone: _____

If we will be filing insurance claims on your behalf, please complete the following:
Primary Cardholders Insurance Information

Name of Insured: _____ DOB: _____

Insured's Address: _____

City/State/Zip: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Name of Insured's Employer: _____ Work Phone: _____

SSN of Insured: _____ Relationship to Client: Self Spouse Parent Other: ____

Insurance Name: _____ Policy/ID#: _____

Group#: _____ Mental Health/Provider Phone #: _____

Authorization#: _____
(Please call your insurance carrier prior to first appointment to obtain this number if applicable under your policy)

I understand that:

- ❑ Insurance companies often require pre-authorization. It is your responsibility to obtain, track and provide the authorization number as well as speaking with your insurance company about any deductible, co-pays, or other benefits. Please provide us with this information and a copy of your insurance card upon your first visit and with any changes. Be advised, we do not file secondary insurance claims.
- ❑ I understand that due to insurance requirements, I will be receiving a mental health diagnosis.
- ❑ I have read and understand the section about "Structure and Cost of Sessions: I understand that my insurance is being filed as a courtesy to me, however, **if a claim is not paid within 60 days or denied, the balance is my responsibility.**
- ❑ I have read, received a copy of, and understand my rights under HIPPA. I authorize North Gwinnett Counseling Associates, LLC to provide any information necessary to my insurance company in order to properly bill claims.

If you will be paying out of pocket:
Amount agreed upon per session: _____ Client Initials_____Therapist Initials_____

I understand that:

- ❑ I have read and understand the section about "Structure and Cost of Sessions:" If payment is not received within 60 days, I may be sent to collections.
- ❑ I understand that my insurance cannot be billed in the future for these sessions already completed.
- ❑ I have read, received a copy of, and understand my rights under HIPPA.

_____ _____

Client/Legal Guardian Signature Date