UPLANDS COUNSELING ASSOCIATES - INFORMATION FORM

Date:_____ ❒ New Client ❒ Returning Client (if more than 3 months since your last visit)

CLIENT INFORMATION

Legal Name: (L, F, MI)_____
Preferred Name: _____
Date of Birth: _____ Age: _____ Sex: ❒ Female ❒Male SSN: _____ - _____ - _____
Primary Address: _____
(City) _____ (State) _____ (Zip) _____
Primary Phone: _____ ❒ Home ❒ Work ❒ Cell for _____ ❒ Do NOT leave message
Additional Phone Numbers: *Mark all that apply*
_____ ❒ Home ❒ Work ❒ Cell for _____ ❒ Do NOT leave message ❒ Emergency Only
_____ ❒ Home ❒ Work ❒ Cell for _____ ❒ Do NOT leave message ❒ Emergency Only
Who Referred You To Us? ❒ Doctor: _____ ❒ Friend ❒ Other
DO YOU HAVE MEDICARE? ❒ Yes ❒ No DO YOU HAVE M.A./MEDICAID? ❒ Yes ❒ No
Is condition for which you are seeking treatment related to: ❒ Employment ❒ Auto Accident ❒ Other Accident

RESPONSIBLE PARTY – Complete if client is under eighteen and you must also sign consent form.

Name: (L, F, MI.) _____ Date of Birth: _____
Address: (if different than client) _____
Preferred Phone Number: _____ ❒ Do NOT leave message ❒ Emergency Only
Additional Phone Number: _____ ❒ Do NOT leave message ❒ Emergency Only
Sex: ❒ Female ❒ Male Relationship to Client: _____ SSN: _____ - _____ - _____
Employer: _____ Occupation: _____

INSURANCE INFORMATON – We need a copy of all insurance cards

**PRIMARY INSURANCE COMPANY: _____
Insurance Address: _____
Subscriber or ID #: _____ - _____ Group/File #: _____
Full Name of Policy Holder: _____ Date of Birth: _____
Employer: _____ Relationship to Client: _____
Home address if different than client: _____
Deductible: _____ Co-Payment: _____ Mental Health Coverage Limits: _____
**SECONDARY INSURANCE COMPANY: _____
Insurance Address: _____
Subscriber or ID #: _____ - _____ Group/File #: _____
Full Name of Policy Holder: _____ Date of Birth: _____
Employer: _____ Relationship to Client: _____
Home address if different than client: _____
Deductible: _____ Co-Payment: _____ Mental Health Coverage Limits: _____

For Staff Use Only
Clinician: _____ ❒ Madison ❒ Dodgeville Diagnosis Code: _____

Additional Client Information

Other Persons in Primary Household: Name	Sex (M/F)	Birth date (mo/day/yr)	Relationship to Client

Address of Secondary Household: _____

Phone for Secondary Household: _____ ❒ Home ❒ Cell for _____ ❒ Do NOT leave message

Other Persons in Secondary Household: Name	Sex (M/F)	Birth date (mo/day/yr)	Relationship to Client

Insurance and Billing Policies

Please be aware that **you are ultimately responsible for your entire bill.** However, as a courtesy to you, we will submit claims to your insurance company. Before your first appointment, please be sure you understand your plan's mental health benefits, including co-payments (the portion of the charge you must pay), deductibles (the amount you must pay before your insurance begins paying) and plan benefit limits. If you need assistance in verifying benefits, please ask us. Please **bring your insurance information and ID card to your first appointment.**

Many insurance plans require **preauthorization for mental health services.** Some plans limit the types of services covered, or the number of appointments covered. Please obtain any necessary preauthorization prior to your first appointment, and inform us of benefit limits.

Co-payments and deductibles are payable at the time of service. We reserve the right to charge interest on unpaid balances over 60 days old at 1.5% OR 18% annually.

Late Cancels/Missed Appointments: If you miss or cancel a **therapy appointment** with less than 24 hours notice, you will be charged a fee of $60. **These fees are not payable by insurance.**

MD Late Cancels/Missed Appointments will be billed as follows and are not payable by insurance:
Initial appointment: $137 20 minute follow-up med check: $80 Extensive follow-up med check: $130

Bank fee for returned checks: This $40 bank fee, along with the original amount of the bad check, is payable only in cash, money order, or cashier's check. Any future payments must also be made by these methods.

Responsible Party: If the primary client is a child, the parent or guardian bringing the child in for services is responsible for paying for these services. If you have a financial agreement regarding the child's medical expenses (such as a divorce decree) with the other parent, you are still expected to pay for your child's services, and arrange for your own reimbursement with the other party. If requested, we will provide billing information to the other party.

My signature below indicates that I have read and understood the above information about billing and payment.

CLIENT NAME (PLEASE PRINT): _____

Signed: _____ Date: _____
Client Signature

_____ Date: _____
Responsible Party Signature (if needed)

_____ Date: _____
Witness Signature