UPLANDS COUNSELING ASSOCIATES (UCA) – CLIENT 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: ____ Bio Sex: ❒ Female ❒Male Gender Identity: _____

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

E-Mail: _____ Preferred Appointment Reminders Via: ❒ E-mail ❒ Text Msg

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

Emergency Contact: Name:_____ Phone Number:_____

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

Bio Sex: ❒ Female ❒ Male Relationship to Client: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATON – Please provide a copy of all insurance ID 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)	Date of Birth (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)	Date of Birth (mo/day/yr)	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Insurance and Billing Policies:

Please note 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 behavioral/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 Insurance ID card to your first appointment.**

If paying "out of pocket" (TOS), and not submitting a claim to your health insurance, we are required to provide you with a **Good Faith Estimate (GFE) of your treatment costs.**

Many insurance plans require **preauthorization for behavioral/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 the 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 an appointment with less than 24 hours' notice, you may be charged a fee of $75.00. **This fee is NOT payable by insurance.**

MD Late Cancels/Missed Appointments: If you miss or cancel a MD appointment with less than 24 hours' notice, you may be charged the fee noted below. **These fees are NOT payable by insurance.**

Initial appointment: $165 25-minute follow-up medication check: $105 40-minute follow-up medication check: $150

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