111 Windel Drive, Suite 213
Raleigh, NC 27609
Tel: 919-807-1454
Fax: 714/276-6999
www.changeforlivingcounseling.org
cflcounseling@gmail.com

ADULT INFORMATION FORM

Client Information

Your Name:_______________________________________ Age_______________________

Billing
Address: _________________________ City: ___________________ State:_____ Zip:______

- ❑ ***Check here if okay for billing to be sent to this address.***

Social Security Number:_________________________ Date of Birth:_____________________

Contact Information (***Check which numbers are okay to call/leave confidential message***):

- ❑ Home Phone:____________________
- ❑ Work Phone:____________________
- ❑ Cell Phone: ____________________
- ❑ email:_________________________

Employment Information:

Employer Name:_____________________________ Employer Phone:__________________

Employer Address:____

Treatment Information:

Primary Care Doctor Name: _________________________ Phone:_____________________

Psychiatrist Name:________________________________ Phone:____________________
Fax: ____________________

Current Medications:_______________________ ________________________________
(include dosages)

_________________________ _________________________________

Referral Source:______________________________

In Case of Emergency

Emergency Contact Name:_________________________________

Relationship to You:____Phone:________________

*Signature:____________________________________ Date:_________________________

I agree that above information is true and that a Change for Living Counseling, PLLC provider
can contact emergency contact if medical or mental health emergency should arise.

DO NOT PRINT

FINANCIAL AGREEMENT

You are expected to pay all copays, deductibles, co-insurance, and any past-due balance on your account at the time of service.

I ____, agree to pay my co-pay, deductibles, co-insurance, and any past-due balance that may occur on my account that fall inside or outside my insurance benefits. I will be expected to pay by check* or cash**.**

I further understand that if I want the therapist's billing service to file claims with my insurance company, that I am responsible for providing accurate insurance information, verifying my benefits with my insurance company, and understanding my coverage. I also agree to get preauthorization if this is required by my insurance company. I am also expected to notify the therapist of any changes in insurance coverage and that I will be responsible for any services and charges, such as extended sessions, that are not covered by my insurance plan.

***If checks are returned an additional $25 fee will be charged and all need to be paid with previous balance at next session. All further payments will need to be made by cash or money order.**

Signature:______________________________________ Date:__________________________

DO NOT PRINT

INSURANCE/PAYMENT AUTHORIZATION

In order to file your insurance for you, please check each box below and sign the following signature-on-file form.

- ❑ I authorize use of this form on all my insurance submissions.
- ❑ I authorize release of information to all my insurance carriers.
- ❑ I understand I am responsible for my bill.
- ❑ I understand that my outstanding bills will be sent to the billing address I provided.
- ❑ I authorize Change for Living Counseling PLLC or the billing service representing her, to act as my agent in helping me obtain payment from my insurance carriers.
- ❑ I authorize payment directly to Change for Living Counseling PLLC and hereby assign my right to reimbursement for services rendered to her.
- ❑ I permit a copy of this authorization to be used in place of the original.

Signature:______________________________________ Date:___________________________