



111 Windel Drive, Suite 213
Raleigh, NC 27609
Tel: 919-807-1454
Fax: 888/789-5440
www.ChangeForLivingCounseling.org
CFLcounseling@gmail.com

CHILD INFORMATION FORM

Client Information

Child's 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: _____

Legal Guardian: _____

Mother's Contact Information (Check numbers where okay to call/leave confidential message):
(if involved in treatment)

- Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 email: _____

Father's Contact Information (Check numbers where okay to call/leave confidential message):
(if involved in treatment)

- Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 email: _____

Treatment Information:

Primary Care Doctor Name: _____ Phone: _____

Psychiatrist Name: _____ Phone: _____
Fax: _____

Current Medications: _____
(include dosages) _____

Referral Source: _____

Name Person Completing Form: _____ Relationship to Client: _____

*Signature: _____ Date: _____



111 Windel Drive, Suite 213
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Tel: 919-360-1929
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www.changeforliving.com
changeforliving@yahoo.com

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: _____

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 and/or Michelle Topal, LCSW , 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/or Michelle Topal, LCSW 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: _____