

## Client Information Sheet

<b>TOP PORTION TO BE COMPLETED BY CLIENT (PLEASE PRINT CLEARLY.)</b>			
<b>Client Name</b> (Last, First, Middle)		(Client Home Phone Number) ( ) ( ) ( )	
<b>Address</b> (Number, Street)		(Client Work Phone Number) ( ) ( ) ( )	
(City)		<b>(CLIENT DATE OF BIRTH)</b> (Gender) M( ) F( )	
(State, Zip + 4)		(Client Marital Status) S( ) M( ) D( ) Sep( ) W( )	
<b>Anticipated Co-Pay:</b>	<b>PCP:</b>	(Is Client Full-Time Student?) Yes( ) No( )	<b>(CLIENT SOCIAL SECURITY NUMBER)</b>
<b>Primary Insured Person's Name</b> (Last, First, Middle)		(Insured Person's Home Phone Number) ( ) ( ) ( )	
<b>Address</b> (Number, Street)		(Insured Person's Social Security Number)	
(City)		(Insured Person's Date Of Birth)	
(State, Zip + 4)		(Relationship of Client to Insured Person)	
<b>Name Of Primary Insurance Company</b>		<b>(Policy Number or Medicaid Number)</b>	
<b>Claims Address</b> (Number, Street)		(Group Number)	
(City, State, Zip Code)		(Phone Number) ( ) ( ) ( )	
<b>Secondary Insured Person's Name</b> (Last, First, Middle)		(Insured Person's Home Phone Number) ( ) ( ) ( )	
<b>Address</b> (Number, Street)		(Insured Person's Social Security Number)	
(City)		(Insured Person's Date Of Birth)	
(State, Zip)		(Relationship of Client to Insured Person)	
<b>Name Of Secondary Insurance Company</b>		<b>(Policy Number or Medicaid Number)</b>	
<b>Claims Address</b> (Number, Street)		(Group Number)	
(City, State, Zip Code)		(Phone Number) ( ) ( ) ( )	
<p>I authorize the release of any medical or other information necessary to process claims. I understand that in order to process claims, some of my personal health information may be sent electronically to my insurance company.</p> <p><b><i>I understand that I am financially responsible for any deductible, co-payment, and co-insurance as well as any other charges not covered by my insurance, and will make these payments at the time of service.</i></b></p> <p>I authorize payment of insurance benefits to Thomas Bender, LPCC.</p>			
<b>Signed</b>		<b>Date</b>	
<b>BOTTOM PORTION TO BE COMPLETED BY THOMAS BENDER, LPCC.</b>			
<b>Referring Practitioner:</b>		(NPI)	
<b>Prior Authorization Number From Insurance</b>			
<b>Initial Date Of Service</b>	<b>CPT CODE</b>	<b>ICD9 / DSM IV</b>	<b>Provider Initials</b>