KEVIN CHADBOURNE DOWNS

LICENSED PROFESSIONAL COUNSELOR (LPC), MAC, SAP, MA.,J.D., ATTORNEY

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NEW CLIENT INFORMATION SHEET

DATE:_____ **Marital Status:** ☐ Married ☐ Single ☐ Other_____

CLIENT NAME (Formal Name):_____

DATE OF BIRTH:_____ **SS#**_____ **SEX:** ☐ Male ☐ Female

ADDRESS:_____ **CITY, STATE, ZIP CODE**_____

EMAIL ADDRESS:_____

PHONE NUMBER: Home (__)_____Cell (___)_____Work(___)_____

PRIMARY CARE PHYSICIAN:_____

EMPLOYMENT:_____

Insurance Information-PLEASE FILL OUT ALL INFORMATION COMPLETELY

PRIMARY INSURED NAME (Formal Name):_____Date of Birth:_____

ADDRESS (if different then above):_____

PHONE NUMBER OF PRIMARY INSURED:_____

EMAIL ADDRESS OF PRIMARY INSURED:_____ **SEX:** ☐ Male ☐ Female

SS# OF PRIMARY INSURED:_____ **MARITAL STATUS OF PRIMARY INSURED:** ☐ M ☐ S ☐ Other___

INSURANCE COMPANY NAME:_____ **MEMBER ID#** _____

GROUP # _____ **CUSTOMER SERVICE PHONE NUMBER** (back of card) _____

NAME OF EMPLOYER: _____ **WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?** _____

Do you have secondary insurance cover? ☐ Yes ☐ No

Please provide all Primary Insurance and Secondary Insurance information.

Please provide a copy of the front and back of the insurance card.

Release of Information for Insurance Verification/Authorization of Benefits/Claims Processing/Fee/Payment

PLEASE INITIAL BELOW

_____ I authorize Kevin C. Downs, and its subsidiaries, to check/verify insurance coverage and benefits.

_____ I authorize the release of any medical or other information necessary to process claims related to services provided by Kevin C. Downs.

_____ I authorize payment of medical benefits to Kevin C. Downs for services provided.

_____ I understand and agree that I am financially responsible to pay for co-pay/coinsurance/deductible/other services not covered by my insurance.

_____ _____

Client Signature or Authorized Person's Signature Date

FOR THERAPIST ONLY: Preauthorization Number and Dates: _____

Primary Diagnosis(es):

_____ _____

Therapist Signature Date