

KEVIN CHADBOURNE DOWNS

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

MOUNT PLEASANT ADDICTIONS COUNSELING, LLC / CHARLESTON ADDICTIONS COUNSELING, LLC

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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