Elizabeth J Kowieski, MS, LCPC, CADC / *INSURANCE INTAKE*

Client Name:_____ Date of Birth: _____ Gender: M/F

Billing Address:_____ Marital Status: S M W D

_____

E-mail Address:_____ Okay to send correspondence or statements?____

If minor (under age 18) please write name of legal guardian:_____

Home Phone: _____ Okay to call?_____

Work Phone:_____ Okay to call?_____

Cell Phone:_____ Okay to call?_____

Employer Name: _____ City:_____

Primary Insurance:

Insurance Carrier:_____

Phone Number:_____

Identification Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber Date of Birth:_____

Insurance Claims Mailing Address:_____N/A_____

Secondary Insurance:

Insurance Carrier:_____

Phone Number:_____

Identification Number:_____ Group Number:_____

Subscriber Name:_____ Subscriber Date of Birth_____

Insurance Claims Mailing Address:_____

Please read the following carefully and sign below:

I give permission to Elizabeth Kowieski, LCPC, and billing staff to send required information to my insurance company or my EAP. I am aware that **I am placing my signature on file**. I also understand that **any unpaid balance such as copays, deductibles, and non covered services I will be responsible for**. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that **my insurance or EAP does not cover the cost of missed sessions**.

Signed:_____ Date:_____