

PAMELA BASS COUNSELING SERVICES, PC

Client Information

Name _____ Birthdate _____ Sex M F
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Soc. Sec. Number _____

INSURANCE INFORMATION:

INSURED'S NAME _____ **BIRTHDAY** _____

Employed by _____ Phone _____ # of years _____

Insurance Co. _____ Insured Name & DOB _____ ID # _____

Is there a secondary insurance co? YES NO Name _____ Insured _____

Authorization # _____ Number of Sessions: _____

Spouse _____ How many children _____ # living with you? _____

1st Child/age _____ 2nd _____ 3rd _____ 4th _____

Emergency Name & Phone: _____ Relationship: _____

Name of Doctor: _____ Phone _____

Address: _____ Date of Last Physical: _____

I AUTHORIZE PAMELA BASS COUNSELING SERVICES, PC TO RELEASE THE INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS. I VERIFY THAT ALL INFORMATION IS ACCURATE AND I AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED.

SIGNATURE OF CLIENT/GUARDIAN **DATE**
(IF GUARDIAN): RELATIONSHIP TO CLIENT: _____

Please check one:

I HAVE BEEN OFFERED PAMELA BASS COUNSELING SERVICES PC PRIVACY NOTICE &
_____ **I HAVE DECLINED** OR _____ **I HAVE RECEIVED NOTICE.**
Initial Initial

SIGNATURE OF CLIENT/GUARDIAN **DATE**
(IF GUARDIAN) RELATIONSHIP TO CLIENT: _____