# Family Life Counseling – Carol A. Larson, MA, LIMHP, LPC

124 W 46th Street, Suite 204, Kearney, NE 68847-8348 (308)236-2014

## *CLIENT INFORMATION AND INSURANCE CONSENT FORM*

**Personal Information** **Date:_____**

Client's Full Name: _____ Birth date:_____

Age: _____ Gender: _____ Marital status:_____ Ethnicity:_____

Phone: (cell) _____ (work) _____ (home) _____

Email: _____

Address:_____

Street City State Zip

❑ Check box if you do not wish for me to contact you by mail, email, and/or phone/texting (*circle which to not use)*

Employed? ___Yes ___No Occupation _____

Student? ___Yes ___No Current Grade or Highest Educational Degree: _____

If client is a minor, parent/guardian's name: _____ Relationship: _____

How did you hear about Family Life Counseling? _____

**Person responsible for paying this account** *(if different from client)***:**

Name: _____ Phone:_____Birth date:_____

Address: _____

**Insurance Information:** **____** See photocopy of insurance card

**Do you wish this office to file claims with your insurance company? Yes____ No ____**

**PRIMARY** Insurance Company Name:_____

Name of the Subscriber: _____ Birth date: _____

**SECCONDARY** Insurance Name/Address: _____

Name of the Subscriber: _____ Birth date: _____

**If you have no insurance, how do you plan to handle payment of your account? _____**

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize **Carol A. Larson, LIMHP** of Family Life Counseling to furnish the insurance company with any medical or other information necessary regarding treatment rendered, when so required.

I authorize my insurance company to pay directly to **Carol A. Larson, LIMHP** of Family Life Counseling the benefits otherwise payable to me. I will be responsible for all expenses incidental to treatment not paid under this plan.

Client Signature_____ Date_____

Guardian (if required) _____ Witness: _____