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| THERAPIST NAME  **Jillian Foster LCSW,LCAS** | OFFICE LOCATION  **30 Hendersonville Rd Suite 1 Asheville NC 28803** | INTAKE DATE |

**CLIENT INFORMATION**

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| CLIENT FULL NAME | | | | DATE OF BIRTH |
| ADDRESS | | EMAIL | | SOCIAL SECURITY NUMBER |
| CITY/STATE/ZIP | | GENDER  MALE FEMALE | MARITAL STATUS  SINGLE MARRIED OTHER | |
| HOME PHONE | LEAVE MSG? YES NO | IF A MINOR, NAMES OF PARENTS/GUARDIANS | | |
| WORK PHONE | LEAVE MSG? YES NO | EMPLOYER/SCHOOL | | |
| CELL PHONE | LEAVE MSG? YES NO | EMERGENCY CONTACT NAME/PHONE | | |

**BILLING INFORMATION**

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| **PRIMARY INSURANCE INFORATION** | | | | | **SECONDARY INSURANCE INFORMATION** | | | | | | |
| *A copy of both sides of the insurance card(s) is needed at intake.* | | | | | | | | | | | |
| INSURANCE COMPANY | | | | | INSURANCE COMPANY | | | | | | |
| CLIENT GROUP ID# | | EFFECTIVE DATE | | | CLIENT GROUP ID# | | | EFFECTIVE DATE | | | |
| CLIENT MEMBER ID# | | | | | CLIENT MEMBER ID# | | | | | | |
| SUBSCRIBER NAME | | | | | SUBSCRIBER NAME | | | | | | |
| RELATION TO CLIENT | | | | | RELATION TO CLIENT | | | | | | |
| SUBSCRIBER DOB | | SOCIAL SECURITY NUMBER | | | SUBSCRIBER DOB | | | SOCIAL SECURITY NUMBER | | | |
| SUBSCRIBER ADDRESS | | | | | SUBSCRIBER ADDRESS | | | | | | |
| CITY/STATE/ZIP | | | | | CITY/STATE/ZIP | | | | | | |
| SUBSCRIBER PHONE | | | | LEAVE MSG? YES NO | SUBSCRIBER PHONE | | | | | | LEAVE MSG? YES NO |
| CO-PAY: | CO-INSURANCE: | | \*DEDUCTIBLE: | | COPAY: | CO-INSURANCE: | | | \*DEDUCTIBLE: | | |
| I authorize the release or exchange of information from FBTA to my insurance company, EAP, managed care group, and/or other paying organization to facilitate payment and continued coverage under the mental health benefit of my policy. I consent to have FBTA submit claims on my behalf to my insurance company, EAP, managed care group, or other paying organization and receive payment according to the guidelines of my policy. I understand that I am responsible for payment for services rendered by FBTA regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify FBTA as soon as I am aware of any changes in my health condition or health plan coverage. | | | | | | | | | | | |
| I clearly understand that final responsibility for payment to FBTA for any and all services rendered due at the time of the visit belongs to me. I also understand that if I suspend or terminate my care and treatment for any reason, any outstanding balance will be immediately due and payable.  I fully understand that **24 hour notice of a cancellation is required.** In addition, I am aware that if notice has not been received, a cancellation fee of $60.00 will be charged to me. Any requests for exception to a failed appointment charge needs to be sent in writing to the administrative office. If my account reaches $300 or over 90 days past due, I must pay 50% of the balance prior to my next session. FBTA reserves the right to send past due accounts to a collection agency. | | | | | | | | | | | |
| **SIGNATURE (LEGAL GUARDIAN)** | | | | | | | | | | **DATE** | |
| **\**DEDUCTIBLE REQUIRES A CREDIT CARD ON FILE*** | | | | | | | | | | | |
| VISA MASTERCARD AMERICAN EXPRESS DISCOVER | | | | | CARD NUMBER | | | | | | |
| CARD HOLDER NAME | | | | | | | EXP DATE | | | CVV CODE | |
| I hereby give consent to charge my credit card above for any outstanding balance at the beginning of each month such as deductibles, co-payments, cancellation fees or other amounts my insurance carrier deems payable by me. | | | | | | | | | | | |
| **SIGNATURE (LEGAL GAURDIAN)** | | | | | | | | | | **DATE** | |