

INSURANCE INFORMATION

NO NEED TO WRITE OUT YOUR INSURANCE INFORMATION IF COPY CAN BE MADE OF YOUR CARD.
However, we will still need your signatures below.

Primary Insurance Carrier: _____ Phone: _____

Subscriber's Name: _____ Relationship to patient: _____

Subscriber employed by: _____ Phone: _____

DOB: _____ Insurance ID#: _____ Group/Policy #: _____

Claims address: _____

SECONDARY INSURANCE CARRIER: _____:Phone: _____

Subscriber's Name: _____ Relationship to patient: _____

Subscriber employed by: _____ Phone: _____

DOB: _____: Insurance ID#: _____ Group/Policy #: _____

Claims address: _____

CONFIDENTIALITY All information will be kept confidential and will be made available only to our professional staff. It will not be released to any outside individual or agency without your written permission. Your insurance company may request dates of service, diagnosis, amounts of charges, and certain information as to why services may need to be continued past current authorization by them. Information may be divulged as required by state law, valid court subpoena, or if your counselor believes you to be in imminent danger to yourself or another.

CONSENT FOR TREATMENT and AUTOMATIC TERMINATION OF TREATMENT:

I hereby authorize and consent to psychotherapy services provided by Mr. Ed Fenn. No promise, guarantee or warranty has been made regarding the result of treatment. The nature of the therapeutic relationship requires the person seeking treatment to notify the counselor in case of serious thoughts of suicide. If the counselor is not notified, a workable relationship does not exist. If the person seeking treatment attempts suicide or engages in behavior that reasonably is understood to be life-threatening, and does not first attempt to reach Mr. Fenn, then the person will be considered to be not seriously seeking healthy change, and further sessions will be limited to the time of transition to another counselor, a time likely not exceeding four to six weeks. Your signature below also attests to your understanding and consent to this requirement.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Date: _____

Signature of Parent/Guardian if patient is a minor