Insight Counseling Services of Greater Lansing LLC

PATIENT INFORMATION—PLEASE PRINT AND COMPLETE ALL SECTIONS **TODAY'S DATE:**

Last Name: _____ First Name: _____ M _____

Date of Birth: ___/ ___/ _____ Social Security Number: _____

Address: _____
Street City/State/Zip

Circle all that apply: **Gender**: Male Female Non-Binary Transgender Intersex Other/I prefer not to share

Marital Status: Single Married Divorced Widowed Separated

Employed: Full-time Part-Time Retired None **Student**: Full-time, Part-time, None

Cell Phone: (_____) _____ Can we leave a message? Yes or No Text Appointment Reminders? Yes or No

Alternative Phone: (_____) _____ Can we leave a message? Yes or No

Email address: _____

PRIMARY INSURANCE & SUBSCRIBER INFORMATION

Primary Insurance Name: _____

Subscriber's Name: LAST _____FIRST _____ M _____

Relationship to Subscriber: _____ Subscriber's Date of Birth: _____/ _____/_____

Subscriber Address: _____

Subscriber's ID# _____ SSN_____ Group # _____

Subscriber's Place of Employment _____

SECONDARY INSURANCE:

Subscriber's Name: LAST _____FIRST _____ M _____

Relationship to Subscriber: _____ Subscriber's Date of Birth: _____/ _____/_____

Subscriber Address: _____

Subscriber's ID# _____ SSN_____ Group # _____ Plan# _____

Subscriber's Place of Employment _____

EMERGENCY CONTACT

Name: LAST _____FIRST _____ M _____

Relationship: _____ Phone # (_____) _____ Can we leave a message? Yes or No

Address: _____

FINANCIAL AGREEMENT: All charges are due at the time of service unless other arrangements have been made. A $75.00 fee will be charged for either a no show or late cancellation. A credit card is required to be on file to cover any balances that may occur. I hereby authorize Insight Counseling Services of Greater Lansing LLC to release any and all medical information to the insurance company to process insurance claims on my behalf and authorize assignment of insurance benefits to be paid directly to Insight Counseling Services of Greater Lansing LLC for services provided. I agree to be responsible for any deductibles, co-payments and other fees as determined by my insurance company. I certify this information is true and correct to the best of my knowledge.

Patient or Responsible Party Signature Date

*****FOR OFFICE USE ONLY. Clinician:** **Fee:** **Diagnosis Code:** **Individual/Family**