COMPASS COUNSELING WAUSAU, LLC

CLIENT INFORMATION:

Name: _____DOB: ____/____/_____ Gender: M F
First MI Last

Address: _____ City: _____ State: ____ Zip: _____

Telephone: Cell: (____)_____-_____ Home: (____)_____-_____ Work: (____)_____-_____

Marital Status: S M Other Employer/School: _____

****All Relevant Fields Required****

Primary Insurance Carrier: _____
Policyholder Name: _____ DOB: ____/____/_____ Relationship to Client:_____
Address of Policyholder (if different than client) _____
Member ID: _____ Group Number: _____
Policyholder Telephone: (____)_____-_____ Policyholder Employer: _____
Employee Assistance Program authorization number (if relevant): _____

Secondary Insurance Carrier: _____
Policyholder Name: _____ DOB: ____/____/_____ Relationship to Client:_____
Address of Policyholder (if different than client) _____
Member ID: _____ Group Number: _____
Policyholder Telephone: (____)_____-_____ Policyholder Employer: _____

Person financially responsible for this account **if other than client**:
Name: _____Relationship to Client:_____
Address (if different than client):_____City:_____State:____Zip:_____
Telephone: Cell: (____)_____-_____ Home: (____)_____-_____ Work: (____)_____-_____

AUTHORIZATION FOR THE PAYMENT OF BENEFITS

I hereby authorize payment directly to Compass Counseling Wausau, LLC, if otherwise payable to me, for counseling services rendered at this clinic. I understand and accept all financial responsibility for the deductible amount and for any outstanding after payment of such benefits and denial of payment. I will notify Compass Counseling Wausau, LLC of any changes to my coverage.

I hereby authorize Compass Counseling Wausau, LLC, to release the following information necessary to process my medical insurance claims and the claims of my family members covered by my medical insurance company: Name, date of birth, diagnosis, progress notes, treatment plans, name of insurance company, subscriber's name, and effective date of policy, policy number, group number, and date and times services are provided.

I understand that this authorization is revocable by me at any time but that my revocation of this authorization will result in my personally assuming financial responsibility for services rendered on my behalf that otherwise would have been reimbursed by my insurance company. I understand that a photocopy of this assignment shall be considered as valid as the original.

_____ _____

Signature of Client or Legal Guardian **Date**