Katherine Ziff, Ph.D., LPC
Billing Intake Information

Patient's Name: _____ Today's Date: _____
Address: _____ City: _____State: _____ Zip: _____
Telephone Number: (Work) _____ (Home) _____
Social Security Number _____ Date of Birth: _____
Are you employed? ____Yes ____No
If yes, name of employer: _____

Do you have insurance coverage: ____Yes ____No
If yes, name of insurance company: _____
Address of insurance company: _____
Name of policyholder: _____ Date of birth: _____
Relationship to patient: _____ Group Number: _____
ID or Social Security Number of policyholder: _____

Are you covered by a second insurance company: ____Yes ____No
Name of Policyholder: _____ Date of Birth: _____
Relationship to patient: _____ Group Number: _____
ID or Social Security Number of Policyholder _____

Who referred you to this office: _____

In order to secure payment for my treatment through my insurance company, I authorized KRISTINA HOUSER, Ph.D., LPCC-S, Licensed Psychologist to cooperate with my insurance company's claims and managed care procedures, including releasing sufficient clinical information (for example, diagnosis, symptoms, and treatment plans) to answer their specific questions. I understand the insurance/managed care company is obligated to maintain this information confidentially. I authorize the aforementioned insurance company to make payment directly to Kristina Houser, Ph.D., LPCC-S, Licensed Psychologist. I understand that I am financially responsible for the charges not covered by my insurance and that the entire bill is my responsibility regardless of my insurance coverage.

Signature: _____

_____
Signature of Responsible Party
(If patient is under 18 years of age)