KENNETH J. RENFROW, LPCC - BILLING INTAKE INFORMATION FORM

PATIENT'S NAME; _____ DATE: _____
ADDRESS:_____ CITY: _____ STATE: ____ ZIP: _____
TELEPHONE NUMBER: WORK: _____ HOME: _____
SOCIAL SECURITY NUMBE: _____ DATE OF BIRTH:_____

ARE YOU EMPLOYED? YES:_____ NO: _____
IF YES, NAME AND ADDRESS OF YOUR EMPLOYER: _____
_____

DO YOU HAVE INSURANCE COVERAGE? YES: _____ NO: _____
IF YES, NAME AND ADDRESS OF INSURANCE COMPANY: _____
_____
NAME OF POLICYHODER: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____ GROUP NUMBER: _____
IDENTIFICATION NUMBER: _____

ARE YOU COVERED BY A SECOND INSURANCE COMPANY? YES:___ NO: ___
IF YES, NAME AND ADDRESS OF SECONDARY INSURANCE COMPAY: _____
_____
NAME OF POLICYHOLDER: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____ GROUP NUMBER: _____
IDENTIFICATION NUMBER: _____

WHO REFERRED YOU TO THIS OFFICE? _____

IN ORDER TO SECURE PAYMENT FOR MY TREATMENT THROUGH MY INSURANCE COMPANY, I AUTHORIZE **KENNETH J. RENFROW, LPCC** 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 **KENNETH J. RENFROW, LPCC.** 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: _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY_____
(If patient is under 18 years old)