Marie D. Guillory, M.Ed., LPC, RTC

CLIENT INFORMATION

DATE OF INITIAL CALL TO OUR OFFICE: _____

CLIENT NAME: _____ DOB: ____-____-_____

GENDER: ❑ Male ❑ Female EMAIL: _____

PHONE:
Cell: _____ SS#: _____-_____-_____
Home: _____
Work: _____ DL #: _____ DL STATE: ___

ADDRESS: _____
_____

CITY: _____ STATE: ___ ZIP: _____

EMPLOYER: _____

WILL CLIENT BE USING INSURANCE? ❑ Yes ❑ No EAP?: ❑ Yes ❑ No
EAP VISITS: _____ EAP AUTHORIZATION#: _____
EAP START DATE: ____-____-_____ EAP END DATE: ____-____-_____

SUBSCRIBER NAME: _____ DOB: ____-____-_____
RELATIONSHIP TO CLIENT: _____

GENDER: ❑ Male ❑ Female

PHONE:
Cell: _____ SS#: _____-_____-_____
Home: _____
Work: _____ DL #: _____ DL STATE: ___

ADDRESS: _____
_____

CITY: _____ STATE: ___ ZIP: _____

EMPLOYER: _____

INSURANCE CARRIER: _____ TELE: _____

ID#: _____ GROUP: _____

NOTE: Insurance benefits information obtained from the Clients Insurance company by Marie Denise Guillory, M.Ed.,LPC, RTC's 's staff is not a guarantee of benefits. All benefits are subject to the terms, limits, and exclusions under the members policy on actual date of service.

_____ _____
Signature - Client or Responsible Party Date

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CLIENT INFORMATION

********** *OFFICE USE ONLY* **********

INSURANCE ADDRESS & PAYER ID: _____

_____

With exception to Psych testing, the following is Not Applicable for EAP

INDIVIDUAL DEDUCTIBLE AMOUNT: _____ MET: _____

FAMILY DEDUCTIBLE AMOUNT: _____ MET: _____

EFFECTIVE DATE: _____ CALENDAR/POLICY YEAR: _____

CO-INSURANCE: _____ COPAY AMOUNT: _____

INDIVIDUAL OUT OF POCKET AMOUNT: _____ MET: _____

FAMILY OUT OF POCKET AMOUNT: _____ MET: _____

NUMBER OF VISITS: Unlimited based on medical necessity

AUTH REQUIRED FOR CPT 90791/90834/90837: ❑ Yes X No

(if Yes, which CPT Code) _____ (See Back if Auth Obtained)

AUTH REQUIRED FOR PSYCH TESTING? X Yes ❑ No

USE IF AUTHORIZATION REQUIRED FOR CPT CODE (_____) or OTHER

# of VISITS: _____ AUTHORIZATION#: _____

START DATE: ____-____-_____ END DATE: ____-____-_____

AUTHORIZATION FOR SECOND/EXTEDED EAP (IF APPLICABLE):

EAP VISITS: _____ EAP AUTHORIZATION#: _____

EAP START DATE: ____-____-_____ EAP END DATE: ____-____-_____

NOTES:

Marie D. Guillory, M.Ed., LPC, RTC

CLIENT INFORMATION

CLIENT'S NAME: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

EMERGENCY CONTACT: NAME / PHONE / RELATIONSHIP TO CLIENT:
_____

WHO REFERRED YOU TO THIS OFFICE? _____

BILLING INFORMATION

RESPONSIBLE PARTY: _____
ADDRESS: _____
PHONE: _____

CONTACT METHODS

I prefer to be contacted using the following methods: (check all that apply)

_____ Home Telephone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only
- _____ Acceptable to fax to this number

_____ Written Communication
- _____ Acceptable to mail to home
- _____ Acceptable to mail to office/work

_____ Work Telephone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only

_____ Cell Phone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only

_____ _____
Signature - Client or Responsible Party Date

CLIENT INFORMATION

STATEMENT OF UNDERSTANDING REGARDING CHARGES FOR MENTAL HEALTH SERVICES

I am the person responsible for payment for mental health services rendered by Marie D. Guillory, LPC to _____
Print Client's Name

With the exception of payments made by or due from insurance that covers mental health services, I understand that my part of the bill for these services is in default 30 days after the services are rendered. When insurance refuses to cover these charges, the bill is in default 30 days after the insurance declares the bill to not be covered by insurance.

I understand and agree that I shall be liable for all and all collection expenses should my bill for mental health services come into defaults.

_____ _____
Signature – Responsible Party Date

_____ _____
Print Name Date of Birth