Nathaniel Marshall Counseling, PLLC
Nathaniel Marshall, LPC, NCC, MC

2200 E. Williams Field Rd. Ste. 200
Gilbert, Arizona 85295

480-332-4397 (office)
480-835-0646 (fax)

CLIENT INFORMATION

SECTION 1:

TODAY'S DATE: _____ /_____/_____ DOB:_____ /_____/_____

PATIENT NAME_____ GENDER: F / M AGE_____

SOCIAL SECURITY # _____ LIVING ARRANGEMENT/MARITAL STATUS _____

ADDRESS _____
Street City State Zip

HOME PHONE_____ WORK PHONE _____

CELL PHONE_____ AT WHICH PHONE MAY WE LEAVE A MESSAGE? _____

EMAIL ADDRESS: _____

JOB (if employed): _____

IN CASE OF EMERGENCY NOTIFY_____ PHONE_____

NAME OF PRIMARY PHYSICIAN_____ PHONE _____

REFERRED BY _____

Insurance for treatment is billed through this office as a courtesy to our patients. Please understand that this in no way takes away the responsibility for payment from the individual patient. An estimate of the patient's portion/co-payment will be given to the patient and payment of this amount is expected at the time of service. By requesting insurance billing from this office, you authorize the release of any information for claims, certification/case management/quality improvement, and other purposes related to the benefits of your health plan. You also authorize direct payment of benefits to the supplier of services being billed. If you would like us to bill your insurance, please provide the following information:

SECTION 2:

POLICY HOLDER'S NAME: _____ and DOB: ____/____/____

MENTAL HEALTH INSURANCE CARRIER _____

INSURANCE ID # _____ GROUP #: _____

AUTHORIZATION # _____ IF EAP, # OF SESSIONS _____

NAME OF EMPLOYER IF GROUP COVERAGE_____

INSURANCE MAILING ADDRESS _____

_____

INSURANCE PHONE NUMBER _____

CONFIDENTIALITY
All information between counselor and patient is held strictly confidential unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a danger to others.
4. Child/elder abuse/neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS
Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your sessions. Your Provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and co-payments. If your insurance determines you are not eligible for services provided and you choose to proceed with service, you are responsible for full payment.

For those without health plan/insurance coverage, payment arrangements should be made prior to your first visit.

In the event of default of payment, the balance of the account is due in full. The patient will be responsible for any reasonable court costs, attorney fees and/or collection fees incurred.

APPEALS AND GRIEVANCES
In the case of those with managed care health plans, I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are denied certification. I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also understand that should I choose to continue treatment without authorization by my health plan and my Appeal is denied, I will be responsible for payment of sessions not approved.

I also acknowledge that I may submit a Grievance to the Provider or Clinical Group Administrator at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance directly to my insurance carrier.

CONSENT FOR TREATMENT
I further authorize and request that **Nathaniel Marshall, LPC**, carry out behavioral health treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and be subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

RELEASE OF INFORMATION
I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan. (Release of information to provider, family, etc., requires separate form).

I understand and agree to all of the above information.

_____
Patient Name (or Parent/Guardian) Printed

_____ _____
Patient (or Parent/Guardian) Signature Date