Confidential Medical Insurance Billing Record

Personal Information:

Date: ____________Name:____

Date of Birth: ____________________________ Social Security Number: _________________________________

Email Address: ____

Home Phone: __________________________________ Cell Phone: ____________________________________

Address: ____City: _______________ State: _____ Zip: ________

Employer: ____Work Phone: ____________________________

Insurance Information:

Insurance Co: ____

ID #:____Group #______________________

Insurance Co. Phone Number: _____________________Policy Holder's Name__________________________

Policy Holder's Date of Birth: ___________________________ Relationship: ___________________________

Address (if different from above): ____

Secondary Insurance:________________________________ Policy Number:____________________________

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. I hereby authorize payment of medical benefits billed to my insurance company and that any amount authorized is paid directly to the Doctor's office. I hereby accept responsibility for payment for any service provided to me that is not covered by my insurance. I also accept responsibility for all co-payments, deductibles, and coinsurance that my insurance company assigns as my responsibility. I hereby authorize Electronic Medical Claims Consultants, LLC, to act an agent of Shanna Reese, LPC and to bill my Medical Insurance Company on her behalf. I give my authorization to use/disclose my health information which specifically identifies me for billing purposes only.

Patient Signature: ____Date: _________________________

Intake Information

What brings you to counseling today: ______________________________________

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Please list symptoms or concerns and related onsets/timelines:

Concern	How long has this been going on?

What are your preferred pronouns? ______________________________________

What is your relationship status? ______________________________________

Who do you consider to be our immediate family ***(please indicate whether or not you see this person as a supportive individual):***

Current Medical Concerns:

Relevant Medical History:

Current Psychological Treatment/Therapies ***(including outpatient care, hospitalizations, detox/rehabilitation stays, etc.):***

Relevant Treatment History ***(including outpatient care, hospitalizations, detox/rehabilitation stays, etc.):***

Trauma Experience/History:

Family History of Mental Illness or Psychological Concerns ***(please include what family member and the identified concern):***

Substance Use ***(both current and historically – please list substances used, dates started/ended, and amounts):***

Please describe any activities or experiences that you engage in or have engaged in previously that support your mental wellness: