Cathalene Silver
Ed.S., LCPC, LMFT

CATHALENE SILVER, Ed.S., LCPC, LMFT

CLIENT INFORMATION

NAME: _____

REFERRED BY: _____

PAST PSYCHIATRIC/PSYCHOLOGIAL TREATMENT: Y____ N_____

WHEN:_____ **WITH WHOM:** _____

REASON FOR VISIT:_____
_____
_____
_____

MEDICAL PROBLEMS/ILLNESSES:_____
_____
_____
_____

CURRENT MEDICATIONS:
_____
_____
_____

ALLERGIES:
_____

DAILY ALCOHOL INTAKE:_____

RECREATIONAL DRUG USE:_____

SMOKING: Y___ N _____ QUANTITY:_____

EMERGENCY CONTACT: _____**PHONE: (___)**_____

EMERGENCY CONTACT: _____ **PHONE: (___)**_____

CLIENT REGISTRATION FORM

Client Name:_____

Date of Birth: ___/___/_____

Address:_____City:_____

State: _____ Zip: _____

Marital Status: Single_____ Married_____ Other_____

Spouse's Name:_____

Spouse's Employer: _____

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (___)_____ Email: _____

EMPLOYMENT INFORMATION

Employer Name:

_____

Employer Address:

_____

Occupation: _____Status: F/T___ P/T___

Retired___Unemployed___

PHYSICIAN INFORMATION

Primary Care Physician: _____

GUARANTOR INFORMATION

(Individual responsible for payment, if different from client)

Client Relationship to Guarantor:

Self_____ Spouse____ Child____ Other_____

Name:_____ Date of Birth: ____/_____/_____

Address:_____ City & State:_____

Zip:_____ Home Phone: (____) _____ Work Phone: (____) _____

Guarantor's Employer:_____

Employer Address: _____

Employment Status: F/T___ P/T ___ Retired ____ Unemployed ____

INSURANCE INFORMATION

PRIMARY Insurance Name:

_____

Claim Mailing
Address:_____

City:_____ State:_____ Zip:_____

Phone# (____)_____

GROUP # _____
ID#_____

Insured Name (**If different than client):** _____

Date of Birth: __/__/____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) has insurance coverage with _____ and assign directly to CATHALENE SILVER, Ed.S., LCPC, LMFT all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize CATHALENE SILVER, Ed.S., LCPC, LMFT to release all information necessary to secure the payment of benefits. I allow fax transmittal of Medical records if necessary. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company. I consent to the treatment necessary for the care of the above named client. I acknowledge full financial responsibility for services rendered by CATHALENE SILVER, Ed.S., LCPC, LMFT. I understand that the payment of charges incurred is due at the time of service. I have read and fully understand the consent to treat, financial responsibility, and release of medical records information.

Responsible Party's Signature

_____Relationship:_____

Date: _____/_____/_____

Thank you for choosing **CATHALENE SILVER, Ed.S., LCPC, LMFT** as your health care provider. Please understand that payment of your bills is considered part of your treatment plan.

CATHALENE SILVER, Ed.S., LCPC, LMFT accepts insurance from many insurance carriers. As a courtesy, my practice will contact your insurance carrier and review your coverage as well as file your claim with your insurance carrier.

The practice will require you to assign all insurance company payments directly to my office to avoid any misunderstandings regarding payment for professional services. Your insurance coverage is a contract between you and your insurance carrier, however, we will assist you to maximize benefits.

Your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim according to state law. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier to resolve any issues.

My practice firmly believes that a good therapist/client relationship is based upon understanding and good communication. I will make every effort to clarify any understanding you may have concerning your balance. I hope to possibly avoid any disagreement over payment for professional services. If you have any questions regarding your insurance policy or need assistance please contact my office at **(815)513-8485.**

Prompt payment allows me to control costs. Full payment is due at the time of service. The practice accepts checks, Visa and MasterCard. Outstanding accounts costs both of us time and money; therefore, all clients will be required to establish financial arrangements for payment of their accounts. By law all client accounts are due and payable within 30 days of services rendered. As a courtesy, my practice will establish a reasonable monthly plan to accommodate your needs. If this becomes necessary, please speak to me in order to make arrangements, prior to this becoming an issue.

INSURANCE PLAN: If you have an indemnity plan (80/20), 20% payment is due at time of service in addition to any deductibles you are responsible for. If you have a managed care plan (HMO/PPO), co-payments are due at time of service in addition to any deductibles you are responsible for. **MISSED APPOINTMENTS AND FAILURE TO PROVIDE 24 HR. NOTICE WHEN CANCELLING WILL RESULT IN A CHARGE THAT MAY NOT BE REIMBURSABLE BY INSURANCE.**

Client Name Print:_____

Signature_____

Date:_____ Witness_____

Christ Campus Retreat Center

2800 Grove Road

Joliet, IL 60431-7997

Phone: (815)-513-8485

Fax: (815)-701-9015

E-mail: info@cathalenesilver.com

Web: cathalenesilver.com

Client Insurance Information Form

To help ensure that therapy services and the process are not interrupted by insurance issues, I ask that you briefly contact your insurance company. This is essential because mental health benefits can be significantly different than your medical benefits and may even be through a different insurance company. Your being knowledgeable about your mental health coverage will allow you to maximize your insurance benefits and prevent billing problems. **Please bring this completed form to your first appointment.**

Name of insurance company_____

Type of Plan: PPO. HMO. Other _____

Member Name on Card: _____

Member ID: _____Group#:_____

Name and DOB (Date of Birth) of Client Being Seen:_____

_____

For your convenience I have provided a basic script for obtaining the information from your insurance company:

Please call the customer service number on the back of the card. Follow the prompts or press "0" to speak with a Customer Advocate. Once you reach a Customer Advocate, state you are calling to check your mental health/behavioral health benefits, ask the questions listed below and record their responses. You may also ask their names for further verification and for your records.

Is my plan currently active? Yes_____ No_____

Do I have mental health benefits? Yes_____ No_____

Does (insert the name of your insurance company here) provide my mental health benefits? Yes_____ No_____

-if No, please ask the name of the company that does, as well as their number: _____

Do I need pre-approval for Outpatient (Private Practice) Mental Health Services? Yes_____ No____

Is there a limit to my mental health services? (# of sessions per year? Or Lifetime?)_____

Do I have a copay? Yes_____ No___ -If Yes, what is the copay for an

office visit to a mental health provider? $_____

Do I have a deductible? Yes____ No____ -If Yes, what is my individual deductible? $_____ Family deductible? $_____

-For the current year how close am I to meeting my deductible? $_____ out of $_____

Thank you for obtaining this information **prior to your first session.** Please bring this completed form and the new client paperwork form to your first session. Also, please remember to **bring your ID and insurance card.** Feel free to contact me with any questions.