Kathy B. Spurlock, LPC
Client Information Form

TODAY'S DATE:	**DOB:**	
Last Name:	**First Name:**	**MI:**
Mailing Address:		
	May we leave a message:	
Home Phone:	**Yes ____ No_____**	
Cell Phone:	**Yes_____ No_____**	
Work Phone:	**Yes_____ No_____**	
Email Add:	**Yes:_____ No_____**	
Occupation:	**Employer:**	

IN CASE OF EMERGENCY			
Name	**Phone**	**Address**	**Relationship**

REQUIRED SIGNATURES

I clearly understand that I am responsible for payment to Kathy B. Spurlock, LPC, for all services rendered, and such payment is due at the time of the appointment. Additionally, I understand that if I terminate services, any balance will be due immediately. I understand that if I default on any payment as called for in this agreement, Kathy B. Spurlock, LPC will have the right to forward my information to a collection agency and a fee of up to 30% will be added to your account to cover the costs of this action. Kathy B. Spurlock, LPC will not be obligated to provide continuing services to any client who includes Kathy B. Spurlock, LPC as a creditor in any bankruptcy filing. My signature below indicates that I fully understand and agree to these terms.

BILLING SIGNATURE (REQUIRED) **DATE:**
(Person responsible for payment)

My signature below indicates that I have received, I understand, and I consent to services from Kathy B. Spurlock, LPC. Specifically, I have received a copy of the Counseling Policies and Practices, HIPAA Statement and Electronic Communications Agreement. This information has been explained or summarized and any questions I had have been addressed.

SIGNATURE(S) (REQUIRED) **DATE:**

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BILLING/INSURANCE INFORMATION			
Person responsible for payment:	**DOB:**	**Address (if different):**	**Phone:**
Employer:			
Type of Insurance: **BCBS ☐ UHC/UBH ☐ AETNA ☐ MEDCOST ☐ OTHER ☐**			
Co-pay: **$**	**Deductible:** **$**	**Co-insurance:** **$**	
Subscriber's Name		**Subscriber DOB:**	
Client relationship to Subscriber:	**Self**	**Spouse**	**Child** **Other (list)**
Subscriber ID # **Group #**		**Insurance Phone #** **Authorization # (if applicable)**	

- If you are not familiar with your benefit coverage, please call the member services phone number on the back of your card. **It is your responsibility prior to your first appointment, to verify your plan's limitations, deductibles and exclusions.**
- In compliance with health insurance contracts, your co-pay, co-insurance or deductible must be collected at the time of service
- It is your responsibility to immediately provide Kathy B. Spurlock, LPC information of any changes in your insurance benefits, coverage or company.
- It is your responsibility to pay any charges not covered by your insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full.

I authorize Kathy B. Spurlock, LPC to release any medical information to my insurance company which is deemed Necessary to process an insurance claim. I authorize my insurance company to assign benefits to Kathy B. Spurlock, LPC. I understand that I am responsible for payment for services rendered by Kathy B. Spurlock, LPC and that any inaccurate information provided on this form, may result in nonpayment by my insurance company. I agree to notify Kathy B. Spurlock, LPC immediately of any changes in the client's health coverage or condition.

SIGNATURE (Required to bill insurance) **DATE:**
(Insured Party)

CREDIT CARD INFORMATION Card Number: Exp Date: CVV Code:

I hereby give my consent to charge the credit card indicated
For any outstanding balance as a result of deductibles, co-pays, Card Holders Name _____
Co-insurance, or other amounts due according to this agreement
And information provided by my insurance company Signature _____