LifeSolutions Counseling Associates, P.C.

Referral/Registration

Date / Time of Call:_____ **Referred by**:_____

Admission Date:_____ Record #:_____

Client Name:_____

Maiden / Other Name:_____ Sex: M F

Address:_____

City:_____ State:____ Zip:_____ **Phone**:_____

DOB:_____ Age:_____ Client SS#:_____

Marital Status: 1. single 2. widowed 3. married 4. divorced 5. separated
Employer:_____
Phone:_____

Problem / Concern:
_____
_____

Current/Prior Mental Health Services? No Yes Where?
_____
_____

Current Medications:_____
_____

MINOR CLIENTS ONLY:
School: _____
Grade: _____Teacher: _____
Telephone: _____

Father / Step Father Name: _____
DOB:_____ Age:_____ Client SS#:_____
Address: _____
City:_____ State:____ Zip:_____ Phone:_____
Mother / Step Mother Name: _____
DOB:_____ Age:_____ Client SS#:_____
Address: _____
City:_____ State:____ Zip:_____ Phone:_____

Admission Date:_____ Record #_____

LifeSolutions Counseling Associates, P.C.

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS
(Information Requests in Bold are the Most Important to Obtain to Verify Insurance)

Insurance Company_____

Mental Health Outpatient Company_____

Phone Number to verify benefits_____

Insurance Contact Person:_____

Primary Insured_____
Employer_____
I.D.# or Soc.Sec.#_____
Policy #_____
Group #_____
Birth Date_____

****

Office Staff to complete information below

Effective Date of Policy_____
LMHC/LCSW accepted_____
Max Payable Per Session_____
Dr.'s Referral needed_____
Percent Coverage_____
Max Payable per calendar year_____
Number for Precert_____
Precertification ID #_____
Certified by_____
Managed Care Company_____
# of Sessions Authorized_____
Patient Co-pay_____

CLAIMS SENT TO:
Insurance Forms:
Company Forms:
Standard HCFA 1500:

NOTES: _____
_____
_____

Admission Date:_____ Record #_____