Date ___________ Diagnosis ____________

DIEDRICH'S COUNSELING SERVICES, INC.

***Provider: Ellen Diedrich** LPAT, LPC, CTS, ST, CSAC*

~~~~~~ CLIENT CONFIDENTIAL INFORMATION ~~~~~

Name ____Male_______Female________
Address ____
City ____State ______Zip___________
Cell Phone (___)__________________________msg Y N
Email ____ Date of Birth _______________
Emergency Contact(s) Name Relationship Telephone
____

~~~~~~~~ INSURANCE INFORMATION ~~~~~~~~

Primary Insurance _________________________Insured's Name ____________________________
Insured's Soc. Sec. #______________________Subscriber ID#_____________ Group#_____________

Secondary Ins ____________________________Insured's Name ____________________________
Insured's Soc. Sec. #______________________Subscriber ID#_____________ Group#__________

For Minors: Person Responsible______________________________Relationship____________________
Address____
DOB ________________Soc. Sec. #___________________________Phone________________________

~~~~ EMPLOYEE ASSISTANCE PROGRAM (EAP) ~~~~

Name of EAP __________________________________Auth # __________________________________
Number of Sessions _________Effective Date ________________Expiration Date___________________

~~~~~ SELF PAY FEE AGREEMENT ~~~~~

I agree to pay Diedrich's Counseling Services, Inc. $____________ per visit

~~ ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION ~~

I hereby authorize any insurance carrier to make payment directly to **Diedrich's Counseling Services, INC S.C.** of any benefits otherwise payable to me for services provided. I understand that I am financially responsible for all charges whether or not paid by the said insurance.

I hereby authorize **Diedrich's Counseling Services, Inc, S.C./Bayshore Billing Services Inc.** to release to my insurance company(s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to, diagnosis, treatment procedure and/or photocopies of all or part of my record. I also permit a photocopy of other facsimile of this authorization to be used in place of the original assignment.

______________________________ ______________________________ ________________
(Patient or guardian signature) (Witness) (Date)