Journey Counseling Services, PLLC

Client Billing Release and Information

Client Information

Today's Date:	**Home Phone:**
Legal Name:	**Work Phone:**
Street Address:	**Cell Phone:**
City, State, Zip	**DOB:** **M or F** M/F
Emergency Contact:	**Contact's Phone:**

Parent/Guardian Information

Please complete this section if client is under 18 years of age

Legal Name:	**Legal Name:**
DOB:	**DOB:**
Relation to Client:	**Relation to Client:**
Street Address:	**Street Address:**
City, State, Zip:	**City, State, Zip:**
Home Phone:	**Home Phone:**
Work Phone:	**Work Phone:**
Cell Phone:	**Cell Phone:**

Insurance Information/Self Pay

Name of Insured:	**Subscriber Name:**
Insurance Company:	**Employer Name:**
ID #:	**Co-Payment Amount:**
Group/Div#:	☐ **Self Pay Self Pay Fee Amount:**

I authorize the release of any medical and/or other information necessary to process claims associated with the above named client. I authorize payment of medical benefits to Journey Counseling Services, PLLC for all billable services.
I understand and agree that if the insurance company named above denies payment for any reason, I then become responsible for payment of all past /future sessions. I also understand that co-payments are due at the time of my appointment. I understand that I am responsible for the $85.00 fee associated with any missed appointments/appointments not cancelled within 24 hours as insurance companies will not cover this.

Client Signature_____Date_____

Therapist Signature_____Date_____