Jay D. Fellers, LCSW PC

6021 South Syracuse Street, Suite 210
Greenwood Village, CO 80111
303-947-4071
(f) 303-779-3341
jdflcsw@hushmail.com
www.fellerstherapy.com

CLIENT INFORMATION

Client Name___________________________________ Date Of Birth:_________________

Street Address__________________________________ City___________ State:_____ Zip:___________

Marital Status: S M D W Spouse_____________________________________

Home Phone___________________ Work Phone_________________ Cell_______________________

Email____

Client Employer______________________________ Occupation_________________________________

Emergency Contact:_______________________________ Phone(s)_____________________________

Custodial Parent____________________________________ Date Of Birth:_________________

Street Address__________________________________ City___________ State:_____ Zip:___________

Marital Status: S M D W S Spouse______________________________________

Home Phone___________________ Work Phone_________________ Cell_______________________

Parent Employer______________________________ Occupation_________________________________

Email____

Non-Custodial Parent ______________________________ Occupation_________________________________

Street Address__________________________________ City___________ State:_____ Zip:___________

Marital Status: S M D W S Spouse______________________________________

Home Phone___________________ Work Phone_________________ Cell_______________________

Email____

Who has Medical Power of Attorney?____

Who may we thank for referring you?____

Primary Physician:____Phone:______________________________

List any significant health problems:____

____

List any medications you are taking and the dosage:____

____

Have you seen this type of therapist before? YES___NO____If yes, when and with whom?___________________

____

Give a brief description of treatment:____

____

PAYMENT AGREEMENT

Please read & initial:

_____It is understood that payment is due at the time of service unless prior arrangements are made. I/we agree to be responsible for all charges rendered on behalf of the identified client, including any charges not reimbursed (co-pay, deductible, & co-insurance, services not covered, etc.) by my insurance carrier, unless a special arrangement has been agreed-upon in writing.

_____It is further understood that I/We will be financially responsible for missed appointments, unless a 24 hour notice is given prior to the scheduled appointment.

_____It is understood that Jay D. Fellers, LCSW PC does not bill insurance companies, and that I/We will be responsible for all charges,

_____It is understood that if any checks written to Jay D. Fellers, LCSW PC are returned from the bank for any reason will incur additional charges (see disclosure agreement).

_____It is understood that if I/We change address, phone numbers, or any other pertinent information, I/We will notify Jay D. Fellers, LCSW PC as soon as possible.

The signature(s) below indicate that I/We understand that Jay D. Fellers, LCSW PC financial policies, and certify that I/We are financially responsible for services provided. I/We will be responsible for any collection and/or attorney fees and/or court costs associated with use of outside agencies required in the collection of my/our account.

Client(s) Signature (s)____________________________________ Date:___________________

____________________________________ Date:___________________

Responsible Party Signature:______________________________ Date:____________________