Jay D. Fellers, LCSW PC
6021 South Syracuse Way, Suite 201
Greenwood Village, CO 80111
303-947-4071
www.fellerstherapy.com

CLIENT INFORMATION

Client Name____ Date Of Birth:________________

Custodial Parent (if applicable)___________________________ Date Of Birth:________________

Street Address_________________________________ City__________ State:_____ Zip:__________

Social Security #:_____-___-_____ Marital Status: S M D W Spouse_________________________

Home Phone__________________ Work Phone________________ Cell_______________________

Client/Custodial Parent Employer_____________________________ Occupation____________________

Annual Family Income (Custodial Parent)____

Emergency Contact:______________________________ Phone(s)_____________________________

Email____

Non-Custodial Parent (if applicable)____________________________Date Of Birth:_________________

Street Address_________________________________ City__________ State:_____ Zip:___________

Social Security #:_____-___-_____ Marital Status: S M D W Spouse_________________________

Home Phone__________________ Work Phone________________ Cell_______________________

Client/Non-Custodial Parent Employer_____________________________ Occupation____________________

Annual Family Income (Non-Custodial Parent)____

Emergency Contact:______________________________ Phone(s)_________________________________

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:____

____

RESPONSIBLE PARTY INFORMATION (if not Client or Parent)

Name:________________________________ Relationship To Client________________________

Address:_______________________________ City:_____________ State:_____ Zip:___________

Home Phone:___________________________ Work/Cell:_________________________________

Email____

INSURANCE INFORMATION

Insurance Company_____________________________ Phone:_______________________________

Group #:______________________________________ ID#:_________________________________

Policy Holder:__________________________ Date Of Birth:________ Relationship To Client_________

Policy Holder's Social Security #____-___-_____ Employer____________________________________

Please read & initial

INSURANCE AUTHORIZATION TO RELEASE INFORMATION

_____I/We authorize the release of the above provided information and any medical information necessary to (1) provide for adequate professional coverage in the absence of the primary doctor, (2) verify insurance coverage, & (3) to file a claim for insurance benefits related to professional services rendered.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

_____I/We authorize direct payment of insurance benefits from ____________________(insurance company) to Jay D. Fellers LCSW for services rendered.

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 to secondary insurance companies, and that I/We will be responsible for all charges after primary insurance has made payment.

_____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.

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

_____ It is understood that if I/We change insurance companies and that information is not given to Jay D. Fellers, LCSW PC and/or if reimbursement from the new insurance company cannot be approved, I/We are responsible for any charges for all professional services rendered.

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:___________________