KATHY HIGGINS LPC LLC

Kathleen Higgins MS, MA, LPC, LAC, EMDR

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Client Information Form

Client Name: **Date of Birth & Social Security #:**

Street Address: **City/State/Zip:**

Home Phone: **Messages okay? Y or N**

Work Phone: **Messages okay? Y or N**

Other Phone: **Messages okay? Y or N**

Primary Insured: **Relation to Client:**

Employer: **Date of Birth:**

Street Address: **City/State/Zip:**

Primary Insured's Social Security #:

Primary Insurance: **Phone#:**

Visits Authorized: **Copay:**

Member ID#: **Group Number:**

Authorization #: **Client Number:**

By signing below, I agree to the following: (1) I understand that as the client I am ultimately responsible for the cost of all services rendered. (2) As a service to me, Kathy Higgins may bill my insurance company on my behalf. However, I am responsible for verifying insurance coverage and obtaining any necessary pre-authorization. If I fail to do so, I will pay the provider's full customary fees for all services rendered. (3) I authorize the release of any information necessary to process insurance claims (4) I authorize my insurance company to pay Kathy Higgins directly for the services provided to me as the client. (5) I will pay the appropriate co-payment or co-insurance to Kathy Higgins, the provider at the time service is rendered. (6) I understand that I will be billed for missed appointments that are not canceled at least 24 hours in advance and that I am responsible for paying those charges.

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Signature of client/guardian **Date**

Kathy Higgins
Revised 4/13/2020

Diagnosis Code:_____