Nancy L. Walden, M.Ed., LPC, RPT, NCC
Licensed Professional Counselor

INFORMATION AND AUTHORIZATION FORM FOR NANCY WALDEN.

Patient Name _____ Date of Birth _____
Social Security Number _____ Sex: Male or Female
Address _____ City _____ Zip _____
Parent Contact Phone #1 _____ Contact Phone #2 _____
Email Address: _____
(Parent's)

Responsible Party Name _____
Address _____ City _____ Zip _____
Contact Phone #1 _____ Contact Phone #2 _____

Insured's Name _____ Insured's Date of Birth _____
Social Security Number of Insured _____
Insured's Employer _____ Relationship to Insured _____
Insurance Company Name _____
Insurance Company's Phone Number _____
Identification Number _____ Group Number _____

Insured's Name _____ Insured's Date of Birth _____
Social Security Number of Insured _____
Insured's Employer _____ Relationship to Insured _____
Second Insurance Company Name _____
Second Insurance Company's Phone Number _____
Identification Number _____ Group Number _____

Type of Credit Card: Visa or MasterCard Expiration of Card: _____
Name on Card: _____ CVC Code: _____
Credit Card Number : _____

I hereby authorize payment of fees, covered by the insurance company, to be paid directly to the provider. This signature applies to all dates of service for the duration of treatment. I understand this also authorizes the billing agent to give out information to the insurance company in order to obtain payment. If the insurance company does not pay within 60 days, I am ultimately responsible for the entire amount due.

_____ _____
Signature Date

Diag Code (provider fill out please) 1)_____ 2)_____ 3)_____ 4)_____