Paramount Counseling Services

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3900 W. Brown Deer Rd., A117 ◆ Brown Deer ◆ WI ◆ 53209
Phone (414) 465-8101 ◆ Fax (414) 448-6944

REFERRING PHYSICIAN OR FACILITY

NAME

ADDRESS

CITY | STATE | ZIP

PATIENT INFO

LAST NAME | FIRST | MI | BIRTHDATE | SEX | MARITAL STATUS

MAILING ADDRESS | PHYSICAL ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

CITY | STATE | ZIP | CITY | STATE | ZIP

EMAIL | OK TO SEND MESSAGE? Y❑ N❑ | OCCUPATION | EMPLOYER

HOME PHONE | OK TO LEAVE MESSAGE? Y❑ N❑ | CELL PHONE | OK TO LEAVE MESSAGE? Y❑ N❑ | WORK PHONE | OK TO LEAVE MESSAGE? Y❑ N❑

OTHER INFO

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT THAN PATIENT)

LAST NAME | FIRST | MI

ADDRESS

CITY | STATE | ZIP

EMAIL

HOME PHONE | CELL PHONE

EMERGENCY CONTACT

PARENT/GUARDIAN (IF MINOR) ❑ SPOUSE ❑
NEAREST RELATIVE OR FRIEND ❑ SIG. OTHER ❑

LAST NAME | FIRST | MI

ADDRESS

CITY | STATE | ZIP

EMAIL

HOME PHONE | CELL PHONE

INSURANCE

INSURANCE COMPANY | IDENTIFICATION NUMBER | GROUP NUMBER

INSURED'S LAST NAME | FIRST | MI | INSURED'S BIRTHDATE | RELATIONSHIP TO PATIENT

I hereby authorize release of information necessary to file a claim with my insurance company and I hereby assign all mental health benefits paid by my insurance company to Paramount Counseling Services, LLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for any balance not covered by my insurance company. A photocopy of this assignment is valid as the original.

X
PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR) | DATE

X
PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT THAN PATIENT) | DATE

PAYMENT INFO

PREFERRED METHOD OF PAYMENT: CHECK OR CASH AT THE TIME OF APPOINTMENT ❑ MONTHLY AUTOMATIC CREDIT CARD ❑

Regardless of your preferred method of payment, you must provide and maintain on file a valid credit card for collection of all unpaid balances. Please be advised that many Health Savings (HSA, HRA, etc.) cards do not authorize mental health/therapy services to be charged to their cards. In the event that your Health Savings card cannot be charged, our billing service will ask for additional payment info to be kept on file.

CARD HOLDER LAST NAME | FIRST | MI | CARD TYPE: CREDIT ❑ DEBIT ❑ HEALTH SAVINGS ❑

BILLING ADDRESS (IF DIFFERENT THAN MAILING ADDRESS) | CARD NUMBER

CITY | STATE | ZIP | EXPIRATION DATE | 3 DIGIT CCV ON BACK (AMEX 4 DIGIT ON FRONT)

I verify that all information provided is correct and that I, the undersigned, am the card holder of the above credit card. I further verify that the signature below is my signature as indicated on the reverse of my credit card. I hereby authorize Paramount Counseling Services, LLC to charge my indicated credit card without an imprint for any outstanding portions of my account balance.

X
CREDIT CARD HOLDER | DATE