MOVE TOWARD CHANGE LLC

Today's date:	Therapist:

PATIENT INFORMATION

Patient's last name:	First:	MI:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single Married Divorced Widowed Engaged Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

How did you learn of our practice? (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Cell phone no.: ( ) Preferred Phone: Email address:

INSURANCE INFORMATION

(Please include a copy of the front & back of your insurance card.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ Cigna ❑ Magellan ❑ UBH ❑ Tricare
❑ Self-Pay ❑ Medcost ❑ Aetna ❑ EAP ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge

_____ _____

Patient/Guardian signature *Date*

Phone: (919) 386-9251 Fax: 972-347-4116 Web: www.movetowardchange.com Email: hawanya@movetowardchange.com

My signature below indicates that I am consenting to treatment/services at Move Toward Change, LLC. I have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA), Office & Electronic Communication Policies, Social Media Policy and Insurance/Billing Policies. This information has been explained or summarized for me and any questions or concerns I had, were addressed.

Print Name:_____ Signature:_____ Date:_____

I clearly understand that I am ultimately responsible for payment to Move Toward Change, LLC for any and all services rendered and that such payment is due **at the time of the visit.** I also understand that if I suspend or terminate services, any outstanding balance will be immediately due. I understand that if I should default on any payment obligations as called for in this agreement, Move Toward Change, LLC will have the right to forward my information to a collection agency and up to an additional 30% will be assessed to my account to cover the costs of this action. My signature below indicates that I fully understand and agree to these terms.

Print Name:_____ Signature:_____ Date:_____

I authorize Move Toward Change, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Move Toward Change, LLC. I understand that I am responsible for payment for services rendered by Move Toward Change, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Move Toward Change, LLC immediately whenever there are changes in the client's health condition or health plan coverage in the future.

Print Name:_____ Signature:_____ Date:_____