Ellen Dudley MA, LCMHC, CRC
Licensed Clinical Mental Health Counselor
1410 Commonwealth Dr., Suite 101-A (The Atrium)
Wilmington, NC 28403
Mobile: (910) 274-6757 Fax: (910) 915-8386

INSURANCE AND BILLING INFORMATION

DATE: _____ REFERRED BY: _____

CLIENT NAME: _____ DATE OF BIRTH: _____
Last First M.I.

ADDRESS: _____ SEX: ◯ M ◯ F
House # and Street Name

_____
Town/City *State* *Zip*

PHONE: CELL _____ ☐ HOME _____ ☐ WORK _____ ☐
(With your consent, please check the box next to the number I may leave a voice mail message on)

EMAIL: _____ LAST 4 DIGITS OF SS #: _____

PRIMARY CARE PHYSICIAN: _____

CLIENT RELATIONSHIP TO SUBSCRIBER: ☐ **SAME** ☐ **SPOUSE** ☐ **CHILD** ☐ **EX-SPOUSE** ☐ **OTHER** **(CHECK *ONE*)**

INSURED/SUBSCRIBER'S NAME: _____

LAST 4 DIGITS OF INSURED/SUBSCRIBER'S SS #: _____ DOB: _____

ADDRESS: _____

PHONE: CELL _____ HOME _____ WORK _____

INSURED/SUBSCRIBER'S EMPLOYER: _____

INSURANCE/HMO/PPO NAME ID#: _____

CLAIMS ADDRESS: _____

PHONE #: 1-800 _____ -OR- _____

BENEFITS DESCRIPTION (DEDUCTIBLE, COPAYMENTS, MAXIMUM, ETC): _____

_____

OTHER HEALTH INSURANCE? ◯ YES ◯ NO - PLAN NAME & ID#: _____

EMERGENCY CONTACT: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____ PHONE: _____

ADDRESS: _____

I release to Ellen Dudley MA, LCMHC, CRC the above confidential information and authorization to use this information for billing and insurance claims as well as notification to other providers, when indicated. I will pay Ellen Dudley MA, LCMHC, CRC any charges not covered by insurance. I understand I will be charged for missed appointments when not canceled within 24 hours in advance unless otherwise agreed upon.

SIGNATURE: _____ DATE: _____