CLIENT INFORMATION FORM
Jeffrey Nelson, LCSW, PLLC
1777 S. Bellaire St. Ste: 220
Denver, CO 80222

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**

Cell Phone: ____________________ **Messages okay? Y or N**

Emergency Contact Name& Phone: ____
Messages okay? Y or N ***(By providing this name and information you are giving your authorization to Jeff Nelson, LCSW, PLLC to call this person in case of emergency)***

Primary Insured: ____________________ **Relation to Client:** ____________________

Employer: ____________________ **Date of Birth:** ____________________

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

Primary Insurance: ____________________ **Phone#:** ____________________

Visits Authorized: ____________________ **Copay:** ____________________

Member ID#: ____________________ **Group Number:** ____________________

Authorization #: ____________________

By signing below, I agree to the following: (1) I understand that the client is ultimately responsible for the cost of all services rendered. (2) As a service to me, Jeffrey Nelson, LCSW 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 this 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 Jeffrey Nelson, LCSW directly for the services provided to the client. (5**) I will pay the appropriate co-payment or co-insurance at the time service is rendered. (6) I understand that I will be billed for missed appointments that are not cancelled at least 24 hours in advance and that I am responsible for paying those charges. (7) I agree to pay for all costs of collection of the client's delinquent accounts including reasonable attorney fees.** (8) I agree that if my mailing address is written incorrectly, has changed since the date of this form, or is missing from this form, I may receive a bill at a current and verifiable address for any outstanding charges. (9) I agree that I have been advised that Jeff Nelson, LCSW does not testify in court with regard to custody issues and that providing reports for such requires payment prior to delivery and charges are $375.00 / hour.

________________________________ ____________________
Signature of client/guardian Date

________________________________ ____________________
Signature of client/guardian Date

Diagnosis Code: ____________

Jeffrey Nelson, LCSW
Revised 03/2013