CLIENT INFORMATION FORM

Jeffrey Nelson, LCSW
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**

Other Phone: ______________________ **Messages okay? Y or N**

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.

_________________________________ _________________________
Signature of client/guardian Date

_________________________________ _________________________
Signature of client/guardian Date

Jeffrey Nelson, LCSW
Revised 12/2019

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Diagnosis Code: _____________