719 SAWDUST RD, SUITE 331
WOODLANDS, TEXAS 77380-2916
PH: (281) 726-4231

**** PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION ****

A COPY OF YOUR INSURANCE CARD (S) AND DRIVER'S LICENSE IS REQUIRED

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, CONTACT: ________________________PH: ___________________

PRIMARY CARE PHYSICIAN: _________________________________ PH: __________________

____

WHO MAY WE THANK FOR REFERRING YOU? ____

PATIENT INFORMATION (Complete this section only if you are the patient)

PATIENT NAME: ____________________________________DATE OF BIRTH: _______________

(First) (MI) (Last)

PATIENT SEX: _____(MALE) _____(FEMALE) PATIENT SSN: __________________AGE: _______

HOME ADDRESS: ___________________________CITY/STATE: _____________ZIP:__________

HOME PH: ________________ WORK PH: ________________ CELL PH: __________________

PATIENTS EMPLOYER: ____

MARTIAL STATUS: _____SINGLE _____MARRIED _____SEPARATED/DIVORCED

SPOUSE'S NAME____________________EMPLOYER: __________________ PH: ____________

ARE YOU CURRENTLY SEEING ANYONE ELSE IN THE MENTAL HEALTH FIELD: ____YES___NO

IF "YES", NAME: __________________ PH: ______________STILL SEEING: _____YES _____NO

IF PATIENT IS A DEPENDENT

PATIENT NAME: ____________________________________DATE OF BIRTH: _______________

(First) (MI) (Last)

PATIENT SEX: _____(MALE) _____(FEMALE) PATIENT SSN: __________________AGE: _______

HOME ADDRESS: ___________________________CITY/STATE: _____________ZIP:__________

HOME PH: ________________ WORK PH: ________________ CELL PH: __________________

MARTIAL STATUS: ______SINGLE ______MARRIED ______SEPARATED/DIVORCED _____CHILD

IF PATIENT IS A DEPENDENT, IS THE PATIENT A FULL TIME STUDENT? ____ PART TIME? ____

ARE YOU CURRENTLY SEEING ANYONE ELSE IN THE MENTAL HEALTH FIELD: ____YES___NO

IF "YES", NAME: __________________ PH: ______________STILL SEEING: _____YES _____NO

PRIMARY INSURANCE INFORMATION

POLICY HOLDER NAME: ________________________________DATE OF BIRTH: _____________

(First) (MI) (Last)

HOME ADDRESS: ___________________________CITY/STATE: _____________ZIP:__________

SSN: _________________________EMPLOYER: _______________________________________

INSURANCE COMPANY: __________________________ PHONE NUMBER: ________________

MEMBER/SUBSCRIBER ID #: _____________________ GROUP/PLAN #: ___________________

SECONDARY INSURANCE INFORMATION

POLICY HOLDER NAME: ________________________________DATE OF BIRTH: _____________

(First) (MI) (Last)

HOME ADDRESS: ___________________________CITY/STATE: _____________ZIP:__________

SSN: _________________________EMPLOYER: _______________________________________

INSURANCE COMPANY: __________________________ PHONE NUMBER: ________________

MEMBER/SUBSCRIBER ID #: _____________________ GROUP/PLAN #: ___________________

PLEASE READ EACH ITEM CAREFULLY AND INITIAL WHERE INDICATED

____ Initials

ITEM 1– CONSENT FOR TREATMENT (ALL PATIENTS MUST SIGN CONSENT FOR TREATMENT)

I hereby give consent for myself or the named minor patient to be treated by Sarah Evans, M.Ed., NCC, LPC, CART OR Cynthia A. Traylor, MA, LPC, CART. If the above named patient is a minor who is or has been involved in any court proceedings, I have/will provide proof, by the attached court documents, that I have the legal right to request treatment for the above named minor. (If conjoint or marital therapy, both parties must sign consent for treatment.)

____ Initials

ITEM 2 – ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I hereby authorize my insurance carrier to pay benefits directly to Sarah Evans, M.Ed., NCC, LPC, CART/ SOS Life Ring, PLLC OR Cynthia A. Traylor, MA, LPC, CART for services provided to myself or my insured dependent, realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to Sarah Evans, M.Ed., NCC, LPC, CART/ SOS Life Ring OR Cynthia A. Traylor, MA, LPC, CART.

____ Initials

ITEM 3 – MISSED APPOINTMENT / LATE CANCELED APPOINTMENTS

Unless canceled at least 24 hours in advance, my policy is to charge you for missed and late cancelled appointments at my full rate (Individual Therapy = $150.00; Family Therapy = $170.00). I may or may not call to confirm and remind patient of their appointments. Please help me serve you better by keeping scheduled appointments.

____ Initials

ITEM 4 – FINANCIAL POLICY

I acknowledge that I have read understand and accept the financial policies mentioned above for this office.

ITEMS 1-4, INITIALED BY MYSELF, INDICATE MY UNDERSTANDING OF LEGAL AUTHORIZATION FOR SAID TERMS AND CONDITIONS IN CONNECTION WITH THE TREATMENT OF THE ABOVE NAMED PATIENT.

______________________	__________	__________
PATIENT SIGNATURE	**INITIALS**	**DATE**
______________________	__________	__________
RESPONSIBLE PARTY/GUARANTOR SIGNATURE	**INITIALS**	**DATE**

Providers Billing Service

P. O. Box 1138
Willis, Texas 77378-1138
PH: (936) 856-4978 / FAX: (936) 856-6343 / (EM) pbswillis@gmail.com

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
(MUST BE SIGNED IN ORDER FOR US TO BILL YOUR INSURANCE)

I, ____, hereby consent to
(NAME OF PATIENT)

CHERYL WALLER / PROVIDERS BILLING SERVICE
SARAH L. EVANS & CYNTHIA A. TRAYLOR / SOS LIFE RING
(DISCLOSURE MADE BY)

to obtain/disclose information in the course of my diagnosis and/or treatment to:

____
(YOUR INSURANCE COMPANY/MANAGED CARE COMPANY NAME)

______________ ______________ ______________
(SPOUSE) (SIBLING) (OTHER INDIVIDUAL)

The disclosure shall be limited to the following specific types of information:
Insurance Benefits/Verifications, Claim/Payment Status,
Treatment Plans, Authorizations, E-Mailing/Faxing/Online/Electronic Billing

For the purpose of: INSURANCE REIMBURSEMENT / THERAPEUTIC TREATMENT
I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in the event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires:
(ONE YEAR AFTER ALL PAYMENTS RECEIVED)

______________ ______________________________
(DATE) (SIGNATURE OF PATIENT)

______________ ______________________________
(WITNESS) (SIGNATURE OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE)