# Ephesians Professional Counseling

Leslie J. Marler, MS, NBCC, LCPC FAX: 301-530-1146

## REGISTRATION INFORMATION (Please fill out in BLACK ink only)

Client Name_____ DOB_____
(Last) (First) (M.I.)

Address_____
(Street) (City) (State) (Zip)

Phone_____ E-Mail_____ SS#_____

Client Is: ___Male ___Female ___Single ___Married ___Divorced ___Student ___Other

Briefly describe symptoms, illness or accident_____

_____ Date of onset of symptoms_____

Employer (Company Name / School Name)_____

Address_____
(Street) (City) (State) (Zip)

Occupation_____ Driver's License #_____

Name of doctor or person who referred you_____

## INSURANCE INFORMATION

Policy Holder's Name_____ DOB_____

Phone_____ E-Mail_____ SS#_____

Address_____
(Street) (City) (State) (Zip)

Insurance Co._____ ID #_____ Group #_____

Ins. Phone_____ Effective Date_____

Relationship to Client: ___Self ___Spouse ___Parent ___Other

**I understand that Insurance coverage is not a guarantee of benefits and that determination will be made at the time the claim is received. I also understand that I am responsible for the balance if the claim is denied and also for any co-insurance or annual deductible that is applicable. All payments are due at the time of service. I also understand that I am responsible for all appointments and I will be charged a fee of $65 unless I give 24 hours' notice of cancellations. Late fees are due at the next appointment.**

Signature_____ Date_____

# Ephesians Professional Counseling

Leslie J. Marler, MS, NBCC, LCPC FAX: 301-530-1146


Client Name_____

## EMERGENCY INFORMATION – Who to contact in case of emergency

Name_____ Relationship_____

Phone_____

(Home) (Work or Cell)

---

## Assignment and Release

I authorize payment of Medical Benefits to this facility/provider. I authorize release of any medical information necessary to process the claim and/or I also request payment of government benefits either to myself or party who accepts assignment.

Signature_____ Date_____

**********

Below to be completed by provider.

| Diagnosis Date | Dx | Dx | Dx | Dx |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |