Ilene L. Cooper, LCSW
Individual and Family Psychotherapy
INSURANCE FORM
678-245-6191 ilcooper@protonmail.com

Name:_____ Date_____
Last First Middle I

Email:_____ May I email bills/information to you?____
Address:_____
_____

Tele: H( )_____ C ( ) _____ W ( ) _____
Date of Birth: _____ Your age: _____

SS # _____

Children names and ages:

Who may I thank for this referral?_____

Name of Employer and/or school:_____
Employers Address: _____
_____
_____
Occupation: _____ Marital Status: _____
Living together___
Employment Status: Full time Part time FT Student, PT student
Retired Disabled

Relation to Insured: Self Spouse Dependent Other

Name of Insurance: _____
Insurance Company Phone Number:_____
Managed Care Company: _____

Billing Address: _____

Insurance Individual ID # _____
Group # _____

Emergency contact: _____Phone #: _____
Address: _____

Closest Relative: Name:_____ Phone # _____

If you are not the insured party please complete the following items for the insured:

Name of insured:
Address of Insured:

Telephone: H:_____ W: _____ C: _____

Individual ID #_____
Group #_____
Insured's Employer: _____
Insured's Employer/Address: _____
_____

**DATE of BIRTH OF INSURED:
SS # of INSURED:

PLEASE READ:

It is your responsibility to call your insurance company to verify coverage and co pays. Co pays are expected to be paid at each session.

I authorize Ilene L. Cooper LCSW to release such information to my insurance company as is necessary to support the insurance claims filed on my behalf. This may include electronic submission. **I understand that I am responsible for all charges regardless of insurance coverage. I understand that if payment of incurred charges is not received in full, after 90 days of receipt of bills, my debts may be forwarded to collections.**
To lower costs and provide needed flexibility, I understand that I can cancel an appointment without charge to me, provided I do so at least 24 hours in advance. I agree to pay a $40.00 fee for sessions I miss without 24 hour notice (unless there is an emergency) and I am aware these missed sessions cannot be charged to my insurance company. If there are three missed sessions in a year's time, appointments cannot be scheduled in advance but are made the same day.

All sessions except the initial session which is one hour are 45 minutes. Fees are: Initial Evaluation $100 and $85 per session. A sliding scale fee is available upon request or as per your insurance company contract.

I authorize the payments of benefits from insurance directly to Ilene L. Cooper, LCSW
By my signature I have read and agree to the above:
Signature:_____

Printed Name:_____ Date:

Medical Information/surgeries:

Current Medications:

Prescribed by:

Brief Medical History and Current issues:

Primary Care Physician:
Phone number:
Psychiatrist:
Phone number:

Previous counseling experiences (approximate dates and names/results):

What brings you in for counseling today?