The Center for Christian Counseling, Consultation and Training Inc. is a certified outpatient psychotherapy clinic by Wisconsin statute DHS 35 and a certified outpatient Drug and Alcohol clinic under DHS 75, which enables the clinic to receive mandated benefits from Wisconsin-based insurance companies. Our clinic files for reimbursement with your insurance company.

Insurance billing is a courtesy, and the clinic does not accept responsibility for collection of your claim or for negotiating a settlement on a disputed claim. Please notify our office immediately if there is any change of address or insurance during the course of treatment. **Ultimate responsibility for your account is yours.**

Please complete all of section 1 and 2. If you will be using insurance, complete section 3 also. Please contact your insurance company prior to your first visit to verify coverage. If you do not have insurance coverage you will be expected to pay for each session at time of service.

1

CLIENT INFORMATION

Last Name First Middle						Cell Phone Number
Address City State Zip						Home Phone
Social Security #	Sex	Age	Date of Birth	Marital Status		Occupation
Employer			Work Phone		Referral Source (Yellow Pages, Friend, Web, etc.)	
Primary Doctor Name City			Referring Doctor Name City			Spouse's Cell #
Name of Client's Spouse			Birthdate	Children (under 18 at home)		Birthdates
If Child- Mothers Name			Birthdate			
If Child-Fathers Name			Birthdate			

2

PERSON RESPONSIBLE FOR BILL

Last Name First Middle				Relationship to Client
Address City State Zip				Home Phone
Social Security #	Sex	Date of Birth	Marital Status	Occupation
Employer Employer Address (City, State, Zip)				Work Phone
Spouse's Employer				

3

INSURANCE INFORMATION

PRIMARY INSURANCE			**SECONDARY INSURANCE COVERAGE**		
Insurance Name			Insurance Name		
Insurance Street Address			Insurance Street Address		
Insurance City	State	Zip	Insurance City	State	Zip
ID # Group #			ID # Group #		
Policyholder Name		Policyholders D.O.B	Policyholder Name		Policyholders D.O.B
Patient Relationship to Policyholder 1.Self 2. Spouse 3.Child 4.Other			Patient Relationship to Policyholder 1.Self 2. Spouse 3. Child 4. Other		

ASSIGNMENT OF BENEFITS: I hereby authorize THE CENTER FOR CHRISTIAN COUNSELING, CONSULTATION AND TRAINING, INC. to release any medical information necessary to process my insurance claims. I further authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me.

_____ _____

Client Signature Date

_____ _____

Client Signature Date
(If client is a minor, parent or guardian must sign)