Jewell Counseling Services, PC

*11319 P Street * Suite 2A * Omaha, NE 68137*
Phone: 402-933-6677

Registration / Intake Information

PERSONAL INFORMATION: (Complete on behalf of the Patient/Client)

Name: _____
First M. Last

DOB: _____ Male ☐ Female ☐ **SS#:** _____

Street Address: _____

City: _____State: _____ Zip: _____

Phone: Home:_____ Cell:_____ Work:_____

Email: _____Employer: _____

Is it OK to call, contact, and leave message? *(Please check for each phone)*
Home: Yes ☐ No☐ **Cell:** Yes ☐ No☐ **Work:** Yes ☐ No☐

Is it OK to contact and leave message through email? *(Please check box)*
Email: Yes ☐ No ☐

Marital status (circle): single married divorced widow

How did you hear about us? _____

Emergency Contact Information:

Name: _____
Relationship: _____
Employer: _____
Home #: _____
Work #:_____
Cell #:_____

Please circle preferred Emergency Contact Phone: *Home Work Cell*

Family Members & Siblings (In Home):

Name_____ Age_____
Name_____ Age_____
Name_____ Age_____
Name_____ Age_____
Name_____ Age_____

PERSON(s) RESPONSIBLE FOR THIS ACCOUNT:

**Statements will not be sent to a third party, without their written request.

Name: _____ DOB: _____ Phone:_____

Address: _____ SS#: _____

Family Physician: _____ Phone: _____

Medication/Dosage**:** _____

INSURANCE: **Do you wish this office to file claims? Yes☐ No☐**

MIDLANDS CHOICE INSURANCE:
On Insurance card, there will be the name of another Insurance Company, known as Third Party Administrator. PROVIDE THE NAME HERE: _____

Primary Insurance Name: _____Ins. Phone: _____

Insurance Address:_____

Name of Subscriber/Policy Holder:_____ DOB: _____ SS#: _____

ID#: _____Group#: _____ID# of Client (if different than subscriber): _____

Deductible?: $_____ Deductible Met?: _____ Co-pay?: **Yes** ☐ **No** ☐ If yes, amount: $ _____

Do you have Out-of-Network benefits? _____ Is an Authorization required? _____

Secondary Insurance Name:_____

Insurance Address:_____ Insurance Phone: _____

Name of Subscriber/Policy Holder:_____ DOB: _____ SS#: _____

ID#: _____Group#: _____ ID# of Client (if different than subscriber): _____

Deductible?: $_____ Deductible Met?: _____ Co-pay?: **Yes** ☐ **No** ☐ If yes, amount: $ _____

Do you have Out-of-Network benefits? _____ Is an Authorization required? _____

ASSIGNMENT OF INSURANCE BENEFITS:

☐ I hereby authorize **Jewell Counseling Services, PC** to release information necessary to process insurance claims relating to my treatment.

☐ I authorize my insurance company to pay directly to **Jewell Counseling Services, PC** all benefits otherwise payable to me.

☐ **I will be responsible for all expenses related to treatment not paid under this plan(s).**

Client Signature: _____ Date: _____

Guardian (if a minor): _____Witness: _____