Nancy L. Scott LMFT PC

Individual, Couple, & Family Counseling
1234 Pearl Street, Suite 3
Eugene, Oregon 97401
541/343.3577

Client Information

Your Name: _____

Residence or mailing address: _____

_____ Zip _____

Telephone (Home): _____ Is it OK for me to phone you & leave messages?
(Home) YES NO
(Work/Mobile): _____ (Work/Mobile) YES NO

Your birth date: _____

Insurance & Billing Information

Primary Insurance: _____

Address: _____

Telephone: _____ Insured's Employer: _____

Insured's Name: _____ Relationship to Client: _____ Birth date: _____

ID #: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____

Address: _____

Telephone: _____ Insured's Employer: _____

Insured's Name: _____ Relationship to Client: _____ Birth date: _____

ID #: _____ Policy #: _____ Group #: _____

(Office Use: Service Code: _____ DSM: _____)

Assignment of Insurance Benefits and Release of Information:

Fee per session is $120, and subject to increase with advance notice. Payment for therapy, including any deductibles and co-payments, is expected at time of treatment unless other arrangements have been made. Your insurance will be billed, however, if your bill is not paid by your insurance company, you are responsible to pay your bill in full.

Therapy sessions are scheduled for 55 minutes. Missed appointments will be charged the full fee if they are not cancelled with 24 hours advance notice. Missed appointments are not covered by insurance. Cancellations may be phoned in at any time.

In the event that this office will be billing my insurance, I hereby authorize payment directly to the Provider of Service for benefits due for myself or my dependent and authorize release of information for the purposes of billing insurance and coordinating benefits. My signature below indicates that the above is true and that I agree to the terms stated above.

_____ _____
(signature of client) (date)