**Samaritan Counseling Centers, Inc.**
340 Commerce Square
Michigan City, Indiana 46360

**Billing Information Form/New Clients**

| *COUNSELOR USE* | |
|---|---|
| **COUNSELOR:** | **GAF:** |
| **Dx Code:** | **FF__INS__FS $__** |

Thank you for choosing Samaritan Counseling Center. Please complete the information below to help our billing process be efficient and accurate. We abide by the HIPPA privacy standards in our billing practices. Our billing services are managed by Samaritan Counseling Centers, Inc. Michigan City, Indiana.

**First MI Last** **M/F** **Today's Date:**

Clients Name: Gender: / /

Home Address: City State Zip

*Home Phone # ( ) *Cell Phone # ( )

*Spouse/Parent/Other Phone # ( ) Employer:

*Initial if Ok to Leave Messages at the Numbers Provided.

| Date of Birth: Social Security Number | Marital Status: Single ___ | Ethnic Backround: African American___ |
|---|---|---|
| ____/____/____ _____-___-_____ | Married___ Separated ___ | Asian American___ Caucasian___ |
| Age:____ | Divorced ___Widowed ___ | Hispanic___ Other:___ |

Please list all names related to billing on this account:

| Name Age Date of Birth | Gender | Occupation/Employer |
|---|---|---|
| | | |
| | | |
| | | |

**WHO IS RESPONSIBLE FOR THIS ACCOUNT?** Name:_____ Date of Birth:_____

Social Security Number (if different from number provided above): _____-___-_____

Address/Phone (if different from client name above):_____ _____

**WILL YOU BE USING INSURANCE? ___Yes ___ No IF YES, PLEASE LET US PHOTOCOPY YOUR INSURANCE CARD.**

Patients or Authorized Persons Signature -

> I authorize the release of any medical, mental or other health information necessary to process this claim.
> I authorize payment of medical benefits to Samaritan Counseling Centers, Inc. for services rendered.
> ***I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM.***

*PLEASE SIGN* _____ *DATE* _____

**CANCELLATION & RETURN CHECK POLICIES**

* **Because counseling hours are reserved, Samaritan Counseling Centers charges for canceled sessions when less than 24 hours notice is given. The missed appointment charge is $30.00.**
* **There will be a $20.00 service charge on all returned checks.**
* **I am aware that I may pay with cash, check, or credit card**

I understand the policies as stated above. Signature_____ Date_____

**Referred By:**_____

**Optional Information that assists our research for grant applications:**

Do you attend church/place of worship now? Church Name_____ City_____

| | | |
|---|---|---|
| **Which of the following categories best describes your household's total income before taxes last year? Please include from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources** | ____ Less than $20,000 | ____ $20,000 - $39,999 |
| | ____ $40,000 - $59,999 | ____ $60,000 - $79,999 |
| | ____ $80,000 - $99,999 | ____ $100,000 or more |