Cypress Creek Counseling
Karen Berner Arcuri, LLC, LMHC
941-920-0189

NEW CLIENT INFORMATION

Last Name	First	Middle	☐ Mr.☐ Mrs. ☐ Ms.	Marital Status ☐ Single☐ Married ☐ Divorced/Separated
Is this your legal name? ☐ Yes ☐ No	If not print legal name	Name known by	Birth Date / /	Age	Sex: ☐ Male ☐ Female
Address	City	St Zip Code	Home Phone - -	Cell Phone - -
Employed ☐ Yes ☐ No Student ☐ Yes ☐ No	Employer: ☐ FT ☐ PT School:		E Mail Address:	
Parent/Guardian Name (If minor)			Phone: - -	

Referred to Provider By: ☐ Dr. _____ ☐Insurance Company ☐ Internet/Website

☐ Family ☐ Friend ☐Professional _____ ☐ Other _____

EMERGENCY CONTACT INFO

Person to Contact in Case of Emergency	Relationship to Client	Home Phone Cell Phone Work Phone

INSURANCE INFORMATION (Please present your insurance card)

Person Responsible for the Bill Date of Birth / /	Address (if different)	Home Phone Cell Phone ( ) - ( ) -
E Mail Address		Relationship to Client ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Primary Insurance/Employee Assistance Program	Policy #	Group #	Authorization #
Insured's Name (If different) Date of Birth / /	Phone Number - -		Relationship to Client ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Secondary Insurance (If Applicable)	Policy #	Insured's Name (if different) Date of Birth / /	

ASSIGNMENT OF BENEFITS /AUTHORIZAITON TO RELEASE INFORMATION

I certify that the above information is correct. I authorize release of medical information necessary to process claims to insurance companies or their agencies for the purpose of fling and payment of medical claims in accordance with FS 394, FS. 395, FS 397, CFR 90.503 and Title 42 Part II, 45 CFR Parts 160 & 164, subparts A&E. I understand that this authorizes release for review by any accrediting surveyor or licensing agent.

I authorize the medical insurance company or employee assistance company listed above to pay directly to the therapist rendering services; Karen Berner Arcuri, LMHC. I understand that I am responsible for all fees, including fees for services not covered by the insurance company including deductibles and co-payments. I may revoke this consent upon written notice.

I further understand that appointments cancelled or rescheduled less than 24 hours' notice will be charged at $35.00

Signature of Responsible Party _____ Date_____

Signature of Provider _____ Date_____