

Therapist: Libby Collins, MA, LMFT  
*Libby Collins Therapy, LLC*

**Client Information and Billing Consent**

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Sex: Male Female \_\_\_\_\_  
City, state, zip: \_\_\_\_\_ Martial Status: \_\_\_\_\_  
(H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_ (C) Phone: \_\_\_\_\_  
If we need to leave you a message, which number should we use? \_\_\_\_\_  
Employer: \_\_\_\_\_ Employment Status: \_\_\_\_\_  
\_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

Referral Source: \_\_\_\_\_ **Fee/copay:** \_\_\_\_\_

**For Minors Only:**  
Parent/Guardian Names: \_\_\_\_\_  
Who has legal custody? \_\_\_\_\_ Physical Custody? \_\_\_\_\_  
Student: Y N Full-time Part-time School: \_\_\_\_\_ Grade: \_\_\_\_\_

<b><u>Primary Insurance</u></b>	<b><u>Secondary Insurance</u></b>
Primary Insured: _____	_____
Insured DOB: _____	_____
Relationship to Insured: _____	_____
Insurance Co: _____	_____
Address: _____	_____
_____	_____
Ins. Phone: ____/____	____/____
Policy/ID#: _____	_____
Group#: _____	_____

I hereby certify that the above statements are correct. I authorize the release of any medical information necessary to process this claim. I also authorize benefits under this claim paid directly to the therapist for services described. I further understand that it is my responsibility to notify the therapist/staff of any changes in my insurance coverage.

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Use Only**  
Axis I Diagnosis \_\_\_\_\_ Date of 1<sup>st</sup> appointment: \_\_\_\_\_  
Prior Authorization Required: \_\_\_\_\_ # of Sessions: \_\_\_\_\_ Approval #: \_\_\_\_\_  
Effective Date of Coverage \_\_\_\_\_ Deductible: \_\_\_\_\_  
Notes: \_\_\_\_\_