Cordova Counseling Center

Patient Contact Information

Client: _____ CCC#:_____

Date of Birth:____/____/____ Marital Status: _____ Social Security #: _____--_____--_____

Address: _____ Home Phone: ( ) _____--_____

City / State / Zip: _____ Cell / Work Phone ( ) _____--_____

Email Address: _____ Referral Source:_____

Insurance Provider: _____ Required Co-pay: $ _____

Name of Insured: _____ Relationship to Client: _____

Policy ID #:_____Group #:_____ Bill Balance To: _____

*I certify that the above information is correct, and hereby authorize Cordova Counseling Center to provide services as deemed necessary for the above named individual(s). I also understand that Cordova Counseling Center charges fees for services rendered, and payment is due at the time of service. I further acknowledge that I have been informed of the fees, and agree to pay them. In the event that your insurance plan does not cover services at Cordova Counseling Center, you are also agreeing to be financially responsible for all charges. Third party billing and payments will be directed to the above client/patient's address unless otherwise specified. Cordova Counseling Center **requires 24-hour advanced notice to cancel an appointment. All appointments that are missed or rescheduled with less than 24-hours advanced notice given to** Cordova Counseling Center **will be billed to you. By signing, you agree to pay the fee for the missed appointment. Additional appointments cannot be scheduled until the missed appointment fee is paid.***

_____ _____

Patient / Client or Guardian Signature Date Witness Signature Date

PLEASE DO NOT WRITE BELOW THIS LINE

Date of Service Service	Staff Initials	Service Provided (CPT Code)	Unit	Billed	Received	Balance	Co-pay Collected	Co-pay Balance

This is a confidential patient medical record. Re-disclosure or transfer is expressly prohibited by Federal and State law.

PT. DX:_____ **NS Fee:** ☐ yes ☐ no

Date of Service Service	Staff Initials	Service Provided (CPT Code)	Unit	Billed	Received	Balance	Co-pay Collected	Co-pay Balance

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by Federal and State law.

PT. DX:_______________________________________ **NS Fee:** ☐ yes ☐ no