Connie Nelson, 2210 W Brown Place, Sioux Falls, 57105 (605) 332-1700

- **CLIENT INFORMATION**

Social Security # ______________________ Date ______________________

Name ______________________ DOB ____________ AGE ________

Address ______________________ Home Phone ______________________
Street/Box #

______________________ Cell Phone ______________________
City State/Zip

Employment ______________________ Work Phone ______________________

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐

- **FAMILY INFORMATION**

Social Security # ______________________ DOB ____________ AGE ________

Parent/Spouse/Partner Name ______________________

Address ______________________ Home Phone ______________________
Street/Box

______________________ Cell Phone ______________________
City State/Zip

Employment ______________________ Work Phone ______________________

- **CHILDREN**

NAME	DOB	AGE	LIVING AT HOME

- Primary Physician: ______________________
- List any medications your are taking and/or any allergies you may have: ______________________
- Who referred you to our office? ______________________
- **CONSULTATION**

I give permission for my therapist to consult with my physician and/or referral source.

______________________ ______________________
Signature Date

Your signature below indicates your written permission allowing me to consult with other qualified therapists as needed.

______________________ ______________________
Signature Date

PLEASE COMPLETE BOTH PAGES

- Other Information:

- **FEES AND INSURANCE**
  - **Initial Assessment & Consultation $150.00**
  - **Individual Therapy, 50 Minute Session $115.00**

Payment of fees is the client's responsibility. You may be charged for failure to appear for your scheduled appointments and/or phone calls of substance. **(Appointments not cancelled 24 hours in advance are considered failed appointments, and you may be charged for them)** Insurance does not cover this.

We will submit an insurance claim for you if you wish. Connie Nelson does not accept responsibility for collecting insurance claims or negotiating a settlement in a disputed claim. The professional services performed at this office are charged to you, not to your insurance company. Therefore, if there is a problem in payment by your insurance company, you will be responsible for prompt payment. If we file a claim for you, we will require you to authorize your insurance company to make payment directly to Mary Eggleston unless you pay in full for each session as services are rendered.

AT MINIMUM, CONNIE NELSON EXPECTS THAT THE CLIENT WILL MAKE CO-PAYMENT (estimated percentage of the fee that insurance will not cover) **AFTER EACH SESSION,** unless alternative arrangements are made with your therapist. Should you wish to discuss fees or charges, you are encouraged to ask your therapist about this. It will be your advantage to make payment promptly as a 1.0 % (12% per year) finance charge may be assessed on all balances 60 or more days past due, regardless of pending insurance payments.

I have read and understand fee and insurance information. Fees associated with therapy will be paid by:

Signature **Date**

- **INSURANCE INFORMATION**

Name of Insured ______ Insured's DOB ______

Carrier ______ ID Number ______

Address ______ Group/Account # ______

______ Co-Pay $ ______

Deductible $ ______ Deductible met? ______

I understand that it is my responsibility to contact my insurance company on pre-authorization procedures.

Signature Date

I hereby authorize Connie Nelson to furnish information to insurance carriers concerning my treatments and hereby assign to the therapist all payments for medical services rendered to myself and my dependents.
I understand that I am responsible for any amount not covered by insurance.

Signature Date