INTEGRATED WELLNESS AND STRATEGIES, LLC
Amber W. Pearson, MA, LPC, EMDR-CT
Your path to healing and transformational growth...

5150 W. 120th Ave, Suite 100
#1057
Westminser, CO 80020
P: 720-644-6378, F: 720-446-3520
strategiesintegrated.com

INSURED CLIENT INFORMATION

GENERAL CLIENT INFORMATION

Date:_____ Client's Nickname: _____

Legal First Name:_____ Legal Last Name_____ MI: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Ok to leave a voicemail? ☐ Yes ☐ No Ok to leave a voicemail? ☐ Yes ☐ No

Date Of Birth:_____ Gender Identification: ☐ Male ☐ Female ☐ Other: _____

Relationship Status (please circle all that apply):

☐ Single ☐ Married ☐ Committed Partner/Spouse ☐ Divorced ☐ Widowed

School Status (circle only one): ☐ F/T Student ☐ P/T Student ☐ Not a Student

Employment Status (circle only one): ☐ F/T Employed ☐ P/T Employed ☐ Unemployed

Clients' Employer:_____ Occupation:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name & ID #:_____

Coverage (Health Plan) Type:_____

Clients' Insurance ID #:_____ Group ID #: _____

Insurance Phone # (for Providers):_____

Co-Payment Amount (payment is required at time of service): ☐ Yes ☐ No ☐ Unknown

If yes, co-payment amount owed at time of service: _____

Co-Insurance Amount (if known): _____ ☐ Unknown ☐ N/A

Is there an "Out-of-pocket deductible" used for counseling (circle one)? ☐ Yes ☐ No ☐ Unknown

Is there "Pre-authorization" requirement before counseling begins (circle one)? ☐ Yes ☐ No ☐ Unknown

Pre-authorization code (provided by client's insurance company): _____ ☐ N/A ☐ Unknown

Additional Primary Insurance Information (if Client is an Insurance Plan Dependent):

First Name of Subscriber:_____ Last Name of Subscriber: _____

Member (Claim) ID # of Subscriber:_____ Group Policy/ID #: _____

DOB of Subscriber:_____ Gender of Subscriber:_____

Relationship of Subscriber to Client:_____Phone # of Subscriber: _____

Subscriber's Address (if different): _____

City: _____State: _____Zip: _____

Subscriber Employer:_____ Occupation:_____

SECONDARY INSURANCE

Insurance Company Name & ID #:_____

Coverage (Health Plan) Type:_____

Group ID #:_____Clients' Insurance ID #: _____

Insurance Phone # (for Providers):_____

How did you hear about me? *Please list ALL websites and sources utilized. Note: If you were referred by a person, I will not contact him/her, I am only asking for tracking purposes.*

_____

_____

By signing below you certify that the client and subscriber listed in this document have active behavioral health coverage with said insurance company. By signing below you also provide express consent to assign all insurance benefits from this company, in relationship to this treatment, directly to Amber W. Pearson and Integrated Wellness and Strategies, LLC. You further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, you are completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. In addition, you hereby authorize Amber W. Pearson, Integrated Wellness and Strategies, LLC, its staff, and its billing agency to release any information necessary to secure the payment of benefits in accordance to HIPAA standards. Lastly, you authorize the use of the signature below on any insurance submissions, whether manually or electronically.

Client Name (printed) Client Signature Date

☐ Copy provided to client.

Form Last Updated: October 6, 2022