INTEGRATED WELLNESS AND STRATEGIES, LLC
Amber W. Pearson, MA, LPC

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Your path to healing and transformational growth...

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:_____________________ Social Security #: ____

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:___________________________

Primary Care Physician (PCP) Name:____

PCP Practice Name: ____

PCP Street Address:____

City:____ State:_______________________ Zip:_________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name :____

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.*

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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.

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Client Name (printed) Client Signature Date

☐ Copy provided to client.