



INTEGRATED WELLNESS AND STRATEGIES, LLC

Amber W. Pearson, MA, LPC

Your path to healing and transformational growth...

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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: _____ 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: _____

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.