

Passages Counseling Center

211 North Monroe Street • Media, PA 19063 • 610-891-9923

Name _____ Date of Birth _____

Address _____ Home phone _____

_____ Work phone _____

Social Security # _____ Cell phone _____

Contact person _____ Contact phone _____

Parents' Names (If dependent) _____

Employer _____ Position _____

Primary physician's name _____ Phone # _____

Referral source _____

Reason for referral _____

Insurance company name _____ Phone # _____

Subscriber's name _____ Subscriber's date of birth _____

Member # _____ Group # _____ Employer _____

Full Fee _____ OR Co-pay \$ _____ OR Deductible \$ _____ & Ins. covers _____ %

Session limits: _____ visits per year Authorization # _____

We reserve the right to charge _____ for appointments cancelled or broken without 24 hours advance notice except in the case of an emergency. Payment is due at the time of service unless other arrangements have been made.

Payment may be made by cash or check. A processing fee of _____ will be charged for each check returned for insufficient funds.

I understand that I am responsible for all charges, regardless of insurance coverage. I give this office permission to release any information obtained during treatment of this patient to support any insurance claims on this account.

I have read and fully understand the above and voluntarily consent to treatment under these conditions.

CLIENT (If over 14 years of age)

WITNESS

CLIENT (Parent/Guardian if minor)

DATE