

Peggy Scaief, LICSW, LLC, BCD  
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**CLIENT INFORMATION: Please print**

Last name:	First Name	MI
Home Phone:	Work Phone:	Cell Phone:
Address:		Birth date: Age:
City:	State:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Zip:		
Employer:		Soc. Sec. #
Address:		
City:	State:	
Zip:		

**PERSON COMPLETING FORM (if other than client)**

Last name:	Home phone:
First name	M.I. Work phone:

**INSURANCE COMPANY INFORMATION**

<p><i><b><u>PLEASE READ CAREFULLY, AS THIS IS A LEGALLY BINDING FINANCIAL AGREEMENT.</u></b> See the Financial Policy for further information. Your primary insurance will be billed if an insurance card is provided as a <u>courtesy</u> to you. Services denied due to missing or incorrect information are <u>client's responsibility</u>. Please verify any <u>pre-authorization requirements</u> and policy limitations for mental health services. Claims over 90 days will be applied to the client's balance. All of this information is necessary to bill.</i></p> <p><b>Secondary insurance is not billed.</b></p>		
Primary Insurance:	ID No.	
Address:	Group/Plan No.	
City:	Zip:	Phone No.
State		
Subscriber Name:	Relationship:	
Address:	Birth date: Age:	
City:	Zip:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
State		