Leslie Ann Shields, M.S., LPC

L.A.'s Well-Being Center

Healthy-Living/Wellness Training, Coaching, Counseling

106 E.24th St. Houston, TX 77008 PH: 832.858.1411 www.lahields.com

(Fax completed form to 713.422.2428 & notify office. Fax must be received to reserve your first appointment)

Client Information Sheet

Referred By: _____ Today's Date: _____,2011

Referred or seeking service for presenting issue of _____

Client Name: _____ Gender: _____ SS#: _____-_____-_____

Date of Birth: _____ Driver's License #& State Issued: _____

Permanent Address: _____ E-mail* _____

City: _____ State: _____ Zip: _____ May we send emails to you @ above address? Yes / No

Cell/Home Phone: _____ Work/Alternate Phone: _____

May we leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Marital Status: (Circle one) single / engaged / co-habitating / partnered / married / separated / divorced / widowed / other (explain)_____

Occupation: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone#: _____

Current Psychiatrist: _____ Phone#: _____

RESPONSIBLE PARTY INFORMATION (If someone other than client will be paying for services or is legal guardian):

Name: _____ Gender: _____ SS#: _____-_____-_____

Relationship to Client: _____ Date of Birth: _____

Address: _____ E-mail* _____

City: _____ State: _____ Zip: _____ May we send emails to named @ above address? Yes/No

Cell/Home Phone: _____ Work/Alternate Phone: _____

May we leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Occupation: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone#: _____ Evening Phone#: _____

Work Phone#: _____ Mobile#: _____

Payment of Services: I will pay for services myself as "Fee for Service" Yes / No (Initial :_____)

I give Authorization of Benefits & Billing to Leslie Ann Shields, MS, LPC as an in-network-provider Yes / No (Initial :_____)

I choose Leslie Ann Shields, MS, LPC as an out-of-network-provider & will need a HCFA 1500 form Yes / No (Initial :_____)

(If utilizing insurance benefits, please continue & complete 'Mental Health Authorization & Billing' Form to initiate services.)

My signature below indicates I authorize the release of any medical or other information necessary for processing and payment of services due to Leslie Ann Shields, M.S., L.P.C. for the "client" named above.

Client Signature: _____ Date: _____

Or Legal Guardian's Signature: _____ Date: _____

Leslie Ann Shields, M.S., L.P.C.

L.A.'s Well-Being Center

Healthy-Living/Wellness Training, Coaching, Counseling

106 E.24th St. Houston, TX 77008 PH: 832.858.1411/ eFAX: 713.422.2428

Insurance Verification & Pre-Certification Authorization Form

(Fax completed form to 713.422.2428 & notify office. Fax must be received to confirm your first appointment)

The information below must be completed in order for you to use your insurance benefits. If this section is not filled out, it is understood insurance does not apply and you will be paying the full fee at the time of service. You have the option to request verification services if you are unable or do not desire completing this form yourself.

If you intend to use your insurance for mental health counseling, call the customer service number on your insurance card and find out the specifics of your coverage & complete all information below. In some cases, this will involve a behavioral health provider network and/or a utilization management company providing any required pre-certification, authorization and benefit payments and may be different from your insurance company (ie: your card may say BCBS, yet 'Compsych' may provide the mental health benefits.) In addition, if provider services are limited to a restricted panel, you must verify whether Leslie Ann Shields, MS, LPC is recognized as an "in-network" member of that provider group. If you were referred or recommended to Leslie Ann Shields, MS, LPC, and she is considered an "out-of-network" provider you may still receive benefit coverage and reimbursement for services and simply pay any difference, similar to traditional medical insurance coverage.

Your Name: _____ D.O.B:_____

Behavioral health management company name:_____

Phone Number (including area code): _____

Your mental health ID # (if different from your insurance plan ID #): _____

Client Co-pay (per Session) $_____ or % of fee client pays $_____# sessions/yr:___

Plan Deductible (if any) $_____Deductible already paid $_____ as of Date:___, 20_

Treatment authorization number (if applicable)_____

Number of sessions authorized_____/code_____

_____/code_____

Circle all Covered codes: 90801/ 90806/ 90876/ 90808/ 90846/ 90847/ 90853/ 90812

(#session allowed wkly:____; Bundling allowed: Y / N; More than 1 unit daily: Y / N)

Claims are mailed to: (Full address):_____

_____

NOTE: COPAYMENT (Cash or Check Only) IS DUE AT THE TIME OF SERVICE. THERE IS A $35 EMR CHART SET-UP/DIGITAL MEDIA FEE REQUIRED OF ALL NEW CLIENTS AT THE FIRST SESSION.

If you prefer, I will verify this info for you, billable @ $35 per1/4 hr. Call 832.858.1411