Kim Shaffer, LCPC Counseling Services LLC
2025 Glenwood Avenue
Hermon, ME 04401
207-991-5818

Identifying Information/Demographics

Status of Enrollment: ___New Client ___Re-Open ___ Information Update ____Substance Use ___ Individual Therapy ____Family Therapy
Clinician: Kim Shaffer, LCPC

DEMOGRAPHICS			
Client's Name			Date of Birth
Address		City	State/Zip Code
Cell/Home Phone		Work Phone	Okay to call you at work. Y N
Client's Gender Male _____ Female _____Other_____		Marital Status Married____ Single_____ Other __	Referred By:
Emergency Contact Person:	Phone # of Contact:	Client's Physician:	Physician's Phone Number:

Client's Email Address:	Physician's Address:
Are you currently receiving either mental health outpatient therapy or substance abuse services from another provider? Yes__ No__ If yes, Provider's Name:_____	Name of Parent or Guardian:
Client's Place of Employment/Work/School:	
PRIMARY INSURANCE INFORMATION	Joint Custody? □ Yes □ No Copy of Divorce Decree?
Insurance Company:	
Insurance Company Address:	Subscriber/DOB:
ID/Policy Number:	Authorization #:
Group Number:	Amount of Deductible:
Authorization Required: Yes No	Co-Pay: # of Sessions Allowed:
SECONDARY INSURANCE INFORMATION	
Insurance Company:	
Insurance Company Address:	Subscribe/DOB:
ID/Policy Number:	
Group Number:	Deductible:
Authorization Required: Yes No	Co-Pay: # of Sessions Allowed:
	Authorization #:

BY SIGNING BELOW, I CONSENT TO MENTAL HEALTH AND/OR /SUBSTANCE ABUSE TREATMENT PROVIDED BY THIS CLINICIAN AND AUTHORIZE ELECTRONIC BILLING TO BILL MY INSURANCE COMPANY FOR THE DATES OF SERVICES RENDERED TO ME. I AUTHORIZE THIS PRIVATE PRACTICE TO DISCLOSE TO THE CLEARINGHOUSE AND/OR MY INSURANCE COMPANY OR OTHER AUTHORIZED BENEFITS PROVIDER ALL INFORMATION THAT IS CUSTOMARY AND NECESSARY TO PROCESS MY BENEFITS CLAIM (S). IN ADDITION, I AUTHORIZE THIS PRIVATE PRACTICE TO SUBMIT BILLING ON BEHALF OF THE ABOVE- NAMED CLIENT TO RECEIVE PAYMENT FOR SERVICES AND AUTHORIZE PAYMENTS TO BE MADE DIRECTLY TO THIS PRIVATE PRACTICE THERAPIST, AS APPROPRIATE. IT IS UNDERSTOOD THAT THIS DOES NOT GUARANTEE IN ANY WAY THE PAYMENT OF SUCH A CLAIM; THAT SUCH PAYMENT IS SOLELY THE RESPONSIBILITY OF THE CLIENT OR PARENT/GUARDIAN) AND/OR THE BENEFIT PROVIDER NOT THE COUNSELOR. I UNDERSTAND THAT IF I HAVE AN INSURANCE PLAN, WHICH REQUIRES ME TO HAVE A REFERRAL/AUTHORIZATION, AND I DO NOT HAVE ONE FOR MY FIRST VISIT THAT I WILL BE 100% RESPONSIBLE TO PAY THE BILL IN FULL. I ALSO AGREE TO PAY ANY DEDUCTIBLE, COPAY AND/OR CO-INSURANCE AT THE TIME OF MY VISIT AND ANY FEE FOR SERVICE THAT IS NOT COVERED UNDER MY INSURANCE PLAN. BY SIGNING BELOW, I AUTHORIZE THIS CLINICIAN/PRIVATE PRACTICE TO SUBMIT TO A THIRD-PARTY COLLECTIONS AGENCY ANY PAST DUE BALANCES THAT ARE OVER 60-DAYS AFTER TERMINATION OF SERVICES, FOR THE PURPOSES OF OBTAINING PAYMENT FOR THOSE PAST DUE BALANCES. I ALSO UNDERSTAND THAT I AM PERSONALLY AND FINANCIALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED KIM SHAFFER, LCPC 24 HOURS IN ADVANCE. I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

Client/Guardian Signature **Date**