Compass Counseling, LLC
1508 New Pinery Rd.
Portage, WI 53901
(608) 745-4900 Fax: (608) 745-4990

Clinician: __________

Diagnosis:

Billing Information

Client's Name______________________________________ Date of Birth____________ ☐ M ☐F ☐

Address ____________________________________ City ___________ State __________ Zip _________

Home Phone #___________________ Work Phone # __________________ Cell _____________________

Phone Preference ☐H ☐C ☐W Email _________________________

Marital Status ☐Single ☐Married ☐Other Referred by _______________________________________

Parent or guardian name (if client is minor)________________________________ Date of Birth _____________

Address_______________________________________ City_____________ State _______ Zip__________

BILLING INFORMATION

Policy Holder name: _______________________________________ Date of Birth___________

Address (if different than above)_________________________ City________ State _____Zip ______

Relationship to client_______________________________ Employer _______________________________

Driver's License #: ________________________________

_______ **(please initial)** I understand that I am ultimately responsible for the payment of all services received at Compass Counseling, LLC. ***If the client is a minor, the guarantor is considered to be whomever signs this form and is fully responsible for payment of all services. Bills are not able to be split between parties.*** If CC bills a medical insurance company for services, this is done as a courtesy to the client and is not a substitute for the client's responsibility for payment of services.

Payment Options: ☐ Insurance ☐ Self Pay $______(1st session) $______ (45-60 min)☐ CCS ☐ EAP

Failed or late canceled appointments: I understand that I will get one "free" missed appointment or late cancellation (appointment that is cancelled less than 24 hours prior to the appointment). If there are additional appointments missed or cancelled late I understand that I will be put on the waiting list and can only resume treatment when time becomes available to me in my clinician's schedule.

Assignment of benefits

I hereby assign mental health/psychotherapy benefits to which I am entitled (including Medicare, private insurance and other health plan benefits) to Compass Counseling, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original copy. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee Compass Counseling, LLC, to release all information to secure payment on my behalf.

Signature of client/guardian____ Date ___________________

Signature of therapist ____ Date ___________________