

PATIENT INFORMATION

Name _____ Gender Male Female
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____ Ext. _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Marital Status _____
Employer or School _____ Employment Status _____
Who referred you to our office? _____
How would you prefer we contact you: Home Cell Email OK to leave message? Yes No
My email address is _____

PRIMARY INSURANCE INFORMATION

Insurance Co Name _____ ID# _____
Policy/Group # _____ Relationship of patient to insured: _____
Insured's Name _____ Gender Male Female
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____ Ext. _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Marital Status _____
Employer or School _____ Employment Status _____

SECONDARY INSURANCE INFORMATION

Insurance Co Name _____ ID# _____
Policy/Group # _____ Relationship of patient to insured: _____
Insured's Name _____ Gender Male Female
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____ Ext. _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Marital Status _____
Employer or School _____ Employment Status _____

EMPLOYEE ASSISTANCE PROGRAM EAP

EAP _____ Authorization Number: _____
Employer _____ Date of Authorization: ____/____/____
Employee Name _____ Expiration Date: ____/____/____
Client Name _____ DOB ____/____/____
Address: _____
City _____ State _____ Zip _____
Phone _____
Number of sessions authorized _____

NORTHWEST IOWA
COUNSELING ASSOCIATES

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Gary Zeutenhorst, ACSW, LISW
Rhonda Jager-Pippy, LISW
Terry Huisman, LMHC
Rachel Wassenaar, LISW

RESPONSIBLE PARTY INFORMATION

Who is responsible for charges for this patient Patient
 Other—Please complete the following.

Name _____ Relationship to patient: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Work Phone _____ Ext. _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Marital Status _____
Employer or School _____ Employment Status _____

ASSIGNMENT AND RELEASE

I authorize Northwest Iowa Counseling Associates, P.C. to release to the Health Care Financing Administration and its agents any information needed to determine benefits. I understand that my signature below requests payment be made to Northwest Iowa Counseling Associates, P.C. authorizes release of medical information necessary to pay claims. If information regarding supplemental insurance is supplied, I also authorize release of information to that insurer or agency. Because Northwest Iowa Counseling Associates, P.C. accepts Medicare assignment, our providers agree to accept the charge determined by Medicare to be the full charge, and the patient agrees to be personally responsible for deductible, coinsurance and any non-covered services.

Signature of Insured/Guardian Date

EMERGENCY CONTACT

The following person(s) will be contacted to assist in the event of:

1. You are a danger to yourself or others.
2. In the case of a medical emergency.

Name _____ Phone _____

Name of Primary Care Physician: _____
Address: _____
Phone: _____
