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
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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:_______________