Mark S. DeBord, LCSW
First West Counseling Center
212 Cypress Street West Monroe, LA 71291
318-322-1427 Fax: 318-322-1477

NAME:____**DATE:**_____________________**CASE #:**__________

DOB:________________**GENDER:**____________**RACE:**________________ **ETHNICITY:**______________________________

____ **CHECK IF ENGLISH IS PREFERRED LANGUAGE; IF OTHER, PLEASE LIST:** _____________________________

ADDRESS:____

CITY:____**STATE:**_________**ZIP CODE:**______________________________

TELEPHONE: (H)_________________________**(W)**___________________________**(CELL)**____________________________

EMERGENCY CONTACT: ____**RELATIONSHIP:**_____________________

PHONE NUMBER: __________________________ **PERMISSION TO CONTACT IN EMERGENCY (CIRCLE) YES NO**

EMPLOYER:____

INSURANCE:____

REFERRAL SOURCE:____

INSURANCE AUTHORIZATION, ASSIGNMENT, COLLECTIONS, AND MEDICAL RECORDS RELEASE

I hereby authorize the following:

1. Any insurance carrier or managed care organization, including Medicare to release any information regarding the status of my claim directly to this office.
2. My insurance benefits (including major medical, managed care, Medicare and private insurance) to which I, my spouse or my dependents are entitled, to be paid directly to this office.
3. This office to:

a. Furnish information to my insurance carrier, managed care organization, or Medicare concerning my medical history, illness and treatments.
b. Provide medical information to my treating and/or referring physician.
c. Release all information necessary to secure payment of benefits.
d. Transmit information concerning my medical history, illness and treatments by any means of electronic media (fax, email, telemedicine, internet, etc.).

4. A photocopy of this form shall be considered as valid as the original and will remain in effect until revoked by me in writing.
5. In the event of my account not being fully paid 90 days after service is rendered or my account being assigned to collections:

a. I agree to pay the total undiscounted bill (billed charges), the cost of collection, court costs, and reasonable attorney fees.
b. I agree to pay interest on the balance at a rate of 1% per month (12% per year).

6. This office to obtain any medical records necessary.
7. By my signature, I acknowledge that I have read and understand the above information.

Signature: ____ Date: ___________________________