Sheryl Seliger, LCSW

Client information

Name of Client(s): _____

Name of Parents (if client is under 18)**:** _____ **Home Phone:** (___)_____

Address: _____ **Cell Phone:** (___)_____
STREET

_____ **Work Phone:** (___)_____ **ext.**_____
CITY, STATE, ZIP

Birth Date of Client: (m/d/y) ___/___/___ **E-mail:** _____

Primary Doctor: _____ **Phone:** (___)_____

Psychiatrist: _____ **Phone:** (___)_____

Emergency Contact: _____ **Relationship to Client:**_____ **Phone:** (___)_____

Who may I thank for referring you to me? _____

Additional Client Information

Social Security #: _____-_____-_____

Occupation: _____

Employer: _____

Employed: ☐ Full-time ☐ Part-time ☐ Retired

☐ **Is the client a student?** ☐ Full-time ☐ Part-time

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Partner ☐ Legally Separated

Primary Insurance and Insured's Information

(Please fill out only if your insurance is to be billed for mental health diagnosis and psychotherapy treatment.)

Policy Name: _____ **Related to Auto or Work Accident?** ___

Policy #: _____ **Group #:** _____ **Insured's Phone:** (___)_____

Policy Phone #: (___)_____

Insured's
Insured's Name *(if different than the client)*_____ **Birth Date: (m/d/y)** ___/___/___
LAST, FIRST, M.I

Insurance Co. **Insured's**
Billing Address: _____ **Employer:** _____
STREET, CITY, STATE, ZIP

Insured's Gender: ☐ Male ☐ Female **Insured's SS#:** _____-____-_____

Client relationship to insured: ☐ Self ☐ Child ☐ Spouse ☐ Other_____ **Date of 1st symptoms**: ___/___/___

If you have secondary insurance, please ask for an additional form and check here ☐

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Payment Policy:

Payment in full is due at the time of service, unless previous arrangements have been made in advance.
We may be able to accept your copay rather than full payment once we have verified the amount of your copay, and confirmed that your deductible has been met.

You may pay by credit card at time of service.

We are able to bill health insurance companies for treatment of diagnosed mental and emotional health diagnoses. If you wish to have us bill your insurance, your claims will be submitted approximately every 4 weeks. The reimbursement check will be sent directly to you from the insurance company when possible. For plans that only reimburse providers directly, we will write you a reimbursement check once the insurance payment has been received.

Cancellation Policy:

Please provide 24 hours notice if you need to cancel or change an appointment, so we will have the opportunity to offer your time to others on a waiting list. You will be billed in full for missed appointments with less than 24 hours advance cancellation notice. Thank you for your understanding.

Limitations of Services Provided:

Sheryl Seliger, LCSW provides a variety of services including, but not limited to psychotherapy for mental health conditions. Techniques commonly considered to be "alternative health" may be offered to you for your informed consent. You have the right and the responsibility to refuse any and all services that you do not choose, or you are not comfortable with, at any time, for any reason.

While some services offered may provide considerable health benefits, no services provided at our office should be considered medical treatment. Sheryl Seliger may provide health coaching and assist in a health discovery process, but does not diagnose or treat any medical illness or condition. You are responsible to, and will be encouraged to seek licensed medical care for any confirmed or suspected medical health issues. Please ask if you would like help with an appropriate referral.

Thank you for your business and for your trust and confidence in our services.

Sheryl Seliger, LCSW

I understand that in the event of default of payment and the above policies, I agree to pay all collection costs, including but not limited to, reasonable attorney's fees, court costs, costs of preparing documents for court and collection agency fees up to 50% of unpaid balance, whether incurred by filing a lawsuit or otherwise.

Jurisdiction and Venue: The terms and conditions contained within this agreement shall be governed by the laws of the state of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party that is based upon, derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

Client Signature: _____ **Date:** _____
(parent or responsible party if client is under 18)

Print Name: _____