*For Provider Use __ONLY__*

**Provider Name:** Mark OvRick, LISW **Diagnosis Code:**

**Referring Provider:** **Authorization Number:**

# ***New Client Call Sheet***

**CLIENT**

***Client Name***: ______________________________ **SS#**: ______________________

Address: ______________________________________________________________

City: ______________________________ State: __________ Zip: ______________________

***Date of Birth***: ________________ Male: __________ Female: __________ Marital Status: ________________

Home Phone: ______________________________ Cell Phone: ______________________________

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***Notes:***

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**INSURANCE** *Include copy of front and back of insurance card*

***Co-payment*** $ ____________________

***Deductible*** $ ____________________

**Primary Insurance**: ________________ **Policy #**: ______________________ **Group #**: ______________

**Subscriber Name**: ______________________________ **Subscriber Date of Birth**: ____________________

**Subscriber SS#:** ______________________________ **Relationship to Client:** ______________________

**Employer:** ________________________

**Secondary Insurance:** __________________ **Policy #**: ______________________ **Group#:** ______________

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***Eligibility & Benefits:***

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INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carries concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

**Client Signature:** ________________________________________ **Date:** ______________________