# Victoria L. Woods, LCSW, LLC

**PATIENT INFORMATION** Please print clearly.

**Last Name:** **First Name:** **MI:** **Birth date:** **Age:**

**Address:** **City, ST, Zip** **SS#:**

**Home Phone:** **Cell Phone:** **Email:**

**Male Female** **Marital Status – Circle One: Single Married Separated Divorced Widowed**

**Employer:** **Employer Add:**

**Work Status – Circle One: FT PT Retired Student**

**RESPONSIBLE PARTY INFORMATION - IF YOU ARE THE RESPONSIBLE PARTY, MARK "SELF" AND MOVE DOWN TO "INSURANCE INFORMATION"**

**PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: SELF SPOUSE DEPENDENT**

**GUARANTOR INFORMATION** Please print clearly.

**Last Name:** **First Name:** **MI:** **Birth date:** **Male Female**

**Address:** **City, ST, Zip** **SS#:**

**Home Phone:** **Cell Phone:** **Work Phone:**

**Email:** **Marital Status – Circle One: Single Married Separated Divorced Widowed**

**Employer:** **Employer Add:**

**Work Status – Circle One: FT PT Retired Student**

*** * * * * IF PATIENT IS A MINOR * * * * ***

- Minor child is accompanied by: (Circle all that apply) **/ Mother / Father / Step-Mother / Step-Father / Legally Adopted Parent / Court Appointed Guardian**
- Child's biological parents are: (Circle one) **/ Married / Divorced / Legally Separated / Never Married**
- If parents are divorced does accompanying parent have: (Circle one) **/ Full Custody / Joint Custody**
- If Joint Custody, does accompanying parent have documentation from Court or written documentation giving permission from the other parent for counseling? (Circle One) **Yes / No** ***If NO please alert this office prior to counseling session.***

**PRIMARY INSURANCE INFORMATION** Please print clearly.

**Carrier:** **Auth #:**

**Policy #:** **Phone # from back of card:**

**Policy Holder:** **Birth date:** **Relationship to Patient – Circle One: Self Spouse Parent Other**

**EAP / SECONDARY INSURANCE INFORMATION** Please print clearly.

**Carrier:** **Type of Insurance – Circle One: EAP / Secondary** **Auth #:**

**Policy #:** **Phone # from back of card:**

**Policy Holder:** **Birth date:** **Relationship to Patient – Circle One: Self Spouse Parent Other**

**ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, PAYMENT AGREEMENT, HIPAA GUIDELINES**

- I understand that payment is due at the time of service unless other arrangements have been made. I understand that Victoria L. Woods, LCSW will be billing

my insurance carrier on my behalf. I understand that Victoria L. Woods, LCSW uses Medical Ancillary Services as her billing service. I agree to have the benefits from my insurance carrier assigned to Victoria L. Woods, LCSW.

- I understand that Victoria L. Woods will make a good effort to verify my insurance; however, I understand that I am responsible for knowing and understanding my insurance benefits and eligibility, and I am responsible for obtaining any and all authorizations necessary for my treatment.
- I permit Victoria L. Woods to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act of 1996).
- I agree that I am responsible for full payment of this account and any court costs and attorney fees associated with the collection of this account.

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**Patient**

**Responsible Party if not Patient** **Date**