Lindsay N. Salem, Ph.D., LLC
3201 Pioneers Blvd, Suite 310 • Lincoln, NE 68502 • Phone 402.488.5413

Client Information & Financial Agreement

_____ _____ _____
Client Name | Gender Identity | Pronouns (optional)

_____ _____ ____/____/____
Client Name on file for insurance | Gender on file for insurance | Date of Birth

_____ _____ _____ _____
Address | City | State | Zip

_____ _____ ___ Cell ___ Home ___ Work _____
Best Phone | 2nd Phone (optional) | Email

_____ _____ _____
Employer | Marital Status | Spouse's/Partner's name (if applicable)

_____ ____/____/____ _____
Individual Responsible for Payment of Fees | Date of Birth | Relationship to Client

_____ _____ _____ _____
Address | City | State | Zip

_____ _____ _____
Phone | Social Security Number | Employer

_____ _____
Referred by (if applicable) | Primary Care Provider

Primary Health Insurance

_____
Insurance Company

_____
Name of Policy Holder

____/____/____ _____
Date of Birth | Relationship to Client

_____
Member ID Number

_____
Group Number (if any)

Secondary Health Insurance

_____
Insurance Company

_____
Name of Policy Holder

____/____/____ _____
Date of Birth | Relationship to Client

_____
Member ID Number

_____
Group Number (if any)

Health History

Medication Currently Used:

Name	Dosage	Frequency	Prescribed by

Past Mental Health Treatment or Counseling:

Name	Dates

Authorizations and Acknowledgments

- I have received a copy of the *Welcome and Disclosure Statement* which lists my responsibilities as a client, including my privacy rights under the Health Information Health Insurance Portability and Accountability Act.

- I understand and agree that, regardless of my health insurance coverage, I am responsible for the balance of my account for any professional service rendered.

- Assignment of Insurance Benefits: I authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents. My signature on this document authorizes Lindsay N. Salem, Ph.D., LLC, and any professional billing service the practice may contract with, to submit claims and understand that I will be bound by this signature as though I had personally signed each claim. I hereby assign directly to Lindsay N. Salem, Ph.D., LLC all benefits otherwise payable to me for services rendered. I understand that any insurance benefits received by Lindsay N. Salem, Ph.D., LLC, and any professional billing service the practice may contract with, on my behalf will be credited to my account in accordance with the above agreement.

- Authorization to treat (if applicable): I authorize treatment of my minor child or ward, named as client in this document.

- I certify that this information is true and complete to the best of my knowledge. I understand that it is my responsibility to notify my therapist of any changes in the above information.

_____ _____

Signature Date