Connie L. Clark, LCPC, NCC, CGRS, SEP
1711 S. 5th Street Springfield, IL 62703
Phone (217) 899-0466 Fax (217) 788-1650

Client Name:_____**Date of Birth:** _____

Gender: M/F **Marital Status: S M W D** **Social Security Number:**_____

Billing Address:_____
_____
E-mail Address:_____

Preference regarding how you receive correspondence or statements:
via email? ____Yes ____No **via Postal Mail? ____Yes ____No**

If minor (under age 18) please write name of legal guardian:_____

Home Phone: _____ **Okay to call? _____Yes _____No**
Work Phone:_____ **Okay to call? _____Yes _____No**
Cell Phone:_____ **Okay to call? _____Yes _____No**

Employer Name: _____ **City:**_____

Primary Insurance:
Insurance Carrier:_____
Phone Number:_____
Identification Number:_____ _____**Group Number:**_____
Subscriber Name: _____ **Subscriber Date of Birth:**_____
Insurance Claims Mailing Address:_____
_____

Secondary Insurance:
Insurance Carrier:_____
Phone Number:_____
Identification Number:_____ **Group Number:**_____
Subscriber Name:_____ **Subscriber Date of Birth**_____
Insurance Claims Mailing Address:_____
_____

Please read the following carefully and sign below:

I give permission to Connie Clark, LCPC, and billing staff, Medox Billing Systems, to send required information to my insurance company or my EAP. I also understand that any unpaid balance such as copays, deductibles, and non-covered services I will be responsible for. I am aware I may receive correspondence from Connie L. Clark and/or her billing staff regarding any outstanding balance due that is payable by me to Connie L. Clark for services rendered by her . I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions. I am aware that I am placing my signature on file.

Signed:_____ **Date:**_____