COMPASS
COUNSELING AND ASSOCIATES

**BIOGRAPHICAL DATA SHEET**

| | |
|---|---|
| **Assigned Therapist:** | |
| **DX Code:** | |

| Name: | Age: | Birth Date: | Gender: |
|---|---|---|---|
| | | | |

| Mailing Address: | Phone: |
|---|---|
| | |

| Is it okay to receive mail? □Yes □No | Is it okay to leave a voicemail? □Yes □No | Is it okay to receive an email? □Yes □No | Is it okay to receive a text? □Yes □No |
|---|---|---|---|

| Email Address: |
|---|
| |

| Spouse's Name | Living | Occupation |
|---|---|---|
| | □Yes □No | |
| Mother's Name | Living | Occupation |
| | □Yes □No | |
| Father's Name | Living | Occupation |
| | □Yes □No | |
| Who referred you to Compass Counseling? | | |
| | | |

**ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM**

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases, the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Primary Insurance Company_____ Phone: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

ID#: _____ Group #: _____ Name of Employer: _____

Relationship to Client: _____ Copay: _____ Deductible/Other: _____



Compass Counseling and Associates
215-260-3748
www.compasscounselingandassociates.com

**Assignment of Benefits**

I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to **Compass Counseling and Associates, LLC** for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information**

I hereby authorize **Compass Counseling and Associates, LLC** to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and or process claims for payment. This information may include, but is not limited to types of service, dates of service, times of service, diagnosis, treatment plans, progress of therapy and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of **Compass Counseling and Associates, LLC**'s Notice of Privacy Practices.
2. Request payment of insurance benefits be made directly to **Compass Counseling and Associates, LLC** for services performed.
3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from **Compass Counseling and Associates, LLC** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____



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