Living Well Counseling and Consulting, LLC
761 N Thornton St., Suite C
Post Falls, ID 83854
208-457-1999

Have you been seen by Kriss Mitchell, ND, M.Ed., LMHC, LPC, CRC before? YES NO

Referred by:_________________________________

CLIENT INFORMATION:
Last Name:_______________________First Name:______________________ Middle Initial:_________
Street address:_______________________________Mailing Address:___________________________________
City:___________________________State:____________Zip:_________Home phone:____________________
Employer:____ Work phone:___________________________
Date of birth:___________________ Age:________ Social Security #_______________________ Sex: M F
Email address:____
Marital status: S M W D Spouse's Name:____
If client is a minor, parent/guardian name:____
Nearest friend or relative not living with you:________________________ Phone #_________________________

Credit Card #_________________________________ Exp Date___________________ CV#_________________

FINANCIAL ARRANGEMENTS: ____ CASH ____ CREDIT CARD ____INSURANCE

(Please bring in copy of insurance card, front and back, for billing purposes)

Primary Insurance Name:____
Subscriber's name:___________________________Subscriber's birthdate:________________________
Subscriber #:______________________ Group #:______________Insurance Phone:________________

Secondary Insurance Name:____
Subscriber's name:___________________________Subscriber's birthdate:________________________
Subscriber #:______________________ Group #:______________Insurance Phone:________________

NAME AND ADDRESS OF PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:

____
____ Phone:_____________________

AUTHORIZATION:

- All of the above information is true to my knowledge
- I authorize this office to release the named insurance company or attorney any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I give permission for credit card information to be maintained by LWCC and payment due to be charged to my credit card unless otherwise requested in writing.
- I authorize and request that insurance payment be made directly to Living Well Counseling and Consulting, LLC should they elect to receive such payment.
- I authorize Living Well Counseling and Consulting, LLC to leave a message with my family or on my answering machine pertaining to appointment reminders or rescheduling.
- After insurance settlement, accounts will be subject to a finance charge at the periodic rate of 1.5% per month, which is an APR of 18%, not including Medicare and Medicaid.

CLIENT/PARENT/GUARDIAN SIGNATURE____**DATE**___________