Anya R. Hunter, MSW, LICSW
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CLIENT INFORMATION

Full name with middle initial: _____

Street address: _____City: _____ZIP: _____

Mailing address: _____ City: _____ZIP: _____

Phone: H: (_____)_____W: (_____)_____Cell: (_____)_____

Email: _____Social security no: _____

Date of birth: _____Sex: M F (circle one)

Relationship to insured: self spouse child other (circle one)

Marital status: single married divorced widowed (circle one)

Is client's condition related to auto accident?_____ other accident?_____ if so, injury date:_____

Referred by:_____

IF USING INSURANCE, WHOSE INSURANCE IS THIS? _____

RESPONSIBLE PARTY INFORMATION (Parent or guardian)

IF YOURSELF, CHECK HERE: _____

IF NOT:

Full name with middle initial: _____

Street address: _____City: _____ZIP: _____

Mailing address: _____Phone: H: (_____)_____W: (_____)_____

Relationship to client: _____

EMPLOYMENT/SCHOOL INFORMATION (for the person who carries the insurance):

Employer/school name: _____

Status: full-time part-time (circle one)

Is client's condition related to employment (past or present)? _____if so, date of injury: _____

INSURANCE INFORMATION:

Primary insurance carrier: (***check Cigna back for CBH/Scranton)*****_____**

Billing address if unusual:_____

Policy #:_____Group #:_____Auth #:_____

Policy holder's name:_____

Policy holder's address: _____City: _____ZIP:

Phone: H: (___)_____W: (___)_____ Cell: (___)_____

Policy holder's social security no.: _____

Policy Holder's date of birth: _____ Policy holder's sex: M F (circle one)

NEW CLIENTS ARE RESPONSIBLE FOR CALLING THEIR INS. CO. & OBTAINING CURRENT INFORMATION BEFORE THE 2nd SESSION.

Deductible/year: _____for mental health only? _____

If no, what does ded include?_____

Session limit/year?_____ Group therapy benefit?_____

Co-insurance for 1 hour: _____ Co-pay for 1 hour: _____Policy limits: _____

Secondary insurance carrier: _____

Billing address if unusual: _____

Policy #:_____Group #:_____Auth #:_____

Policy holder's name:_____ Phone: H: (___)_____W: (___)_____

Social security no: _____Date of birth: _____Sex: M F (circle one)

Policy holder's address: _____City: _____ZIP: _____

Any group therapy benefit?_____ if so, explain: _____

Deductible per calendar year: _____ for both mental health only? _____

If not, then what does deductible include? _____

Co-insurance for 1 hour: _____ Co-pay for 1 hour: _____Policy limits: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I, _____, authorize the release of any medical or other information necessary to process insurance claims. I authorize and request payment of medical/mental health benefits directly to Anya Raven Hunter, LICSW, for psychotherapy services. I agree that this authroization will cover all medical/mental health services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____

Client /Date

In the event medical/mental health serivces provided by Anya Raven Hunter, LICSW are not covered by my medical insurance benefits, I, _____, agree to reimburse Anya Raven Hunter, LICSW for her professional fee according to her POLICIES and as detailed in the FEE AGREEMENT signed by her and me.

_____

Client /Date