Dr. Lewis James Jordan, PhD, LMHC

PAYMENT IS DUE AT TIME OF VISIT

New Client Demographic Billing Form

How did you hear about Dr. Jordan? _____

TODAY'S DATE _____

Client's Full Name: _____

Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Sex: Male Female
Marital Status: Single Separated Married Divorced Widowed

Home Phone: _____Work Phone: _____

Cell Phone: _____

E-mail: _____

Mailing Address:

_____

_____

Physician
Name: _____ Phone: _____

Address: _____

398 Camino Gardens Boulevard Suite 101 Boca Raton, FL 33432 561-347-5099

Dr. Lewis James Jordan, PhD, LMHC

Required Credit Card Authorization Agreement & Cancelation Policy for Therapy Services

Please Read Carefully

Today's Date:_____

Dear Patient/Client,

We understand emergencies may occur and missed appointments may happen. If you need to cancel and/or reschedule please contact the office as soon as possible. **The 24-hr patient hotline voicemail is (954) 399-2093.** We ask for consideration of Dr. Jordan's time. Therapy is a commitment to both Therapist and Client and as such for any "no call / no shows" or last minute cancelations, the **full fee** for services will be billed unless other arrangements are agreed upon by the patient & Dr. Jordan.

**Patients using health insurance* - if you claim is denied, it is the patient responsibility to pay any fees not covered by the insurance company.*

Credit Card Authorization & Service Fee Agreement

Dr. Jordan requires a credit card to be placed on file.
Additionally, you may choose to use this payment method automatically billed for services rendered. If you choose to use this method for automatic billing, a **3% service fee will be added**. By signing below you are giving consent. Your credit card information will be treated with the same confidential considerations as your private patient records and will be kept locked in our billing cabinet as specified in federal HIPPA guidelines. Please fill in the required information below:

_____ _____
Client or Authorized Payee (Print Name) Client or Authorized Payee (Signature)

_____ _____
Credit card # expiration date cvc 3 digit code

*By signing above you are authorizing this card to be billed by **Psychotherapy Services.**
*The office requires payment at time of services. Thank you.

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COMPLETE BELOW ONLY IF USING INSURANCE

PRIMARY INSURANCE

Name of Insurance Co.: _____

Insurance Co. Phone #_____

Insurance Co. Address: (For Submitting Claims)

_____

Policy ID #: _____ Copay/Deductible: _____

Group ID #: _____ Authorization #:_____

Number of visits authorized: _____

PRIMARY POLICY HOLDER INFORMATION (if other than patient)
Name of Primary Policy Holder:
_____

Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Employer: _____

Phone: _____

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