

NORTHSTAR COUNSELING CENTER
6506 SCHROEDER ROAD
MADISON, WI 53711
Phone: (608) 270-1960 / Fax: (608) 270-1965

PATIENT INFORMATION

Name:	Home Phone:
Date of Birth:	Cell Phone:
Address:	Work Phone:
City/State/Zip:	Social Security #:
E-mail:	Male_____ Female_____ Other_____

BILLING INFORMATION Same as Patient Information

Name:	Home Phone:
Date of Birth:	Cell Phone:
Address:	Work Phone:
City/State/Zip:	Social Security #:
Employer:	Male_____ Female_____ Other_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

SECONDARY INSURANCE CARRIER

Company:	Company:
Address:	Address:
City/ST/ZIP:	City/ST/ZIP:
Phone #:	Phone #:
ID or Subscriber #:	ID or Subscriber #:
Group #:	Group #:
Name of Insured:	Name of Insured:

[] I do not have insurance benefits for mental health services and agree to pay my bill personally at the time of visit.

Are you currently in treatment with a psychiatrist, psychologist, psychotherapist or social worker? [] YES [] NO If yes, who?
_____ Phone #: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request the payment be made directly to NorthStar Counseling Center. I agree this authorization will cover all medical services rendered until such authorization is revoked by me. I agree a photocopy of this authorization may be used in place of the original.

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE