MENTAL HEALTH SYSTEMS

Elizabeth POTTER

Client Information Sheet

Last Name:	First:	MI:	DOB:
Address:	City:		State: ZIP:
Home Phone:	Work Phone:		Marital Status:
Primary Care Physician:			Gender:
Emergency Contact:			Phone Number:

Responsible Party for Insurance:	Phone Number:
Responsible Party Birth Date:	Address:
Employer Name:	Email:

Primary Insurance Name:	Insured Name:
Relationship to Client:	Employer Name:
Policy #:	Group #:
Effective Date:	Insurance Phone #:

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that you are required to obtain benefit information prior to services being provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that you will be billed for any outstanding amounts owed to your credit card on file. You are responsible for reporting any insurance changes at the time of your appointment.

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

Elizabeth Potter, PC 10831 Old Mill Road, Suite 100A Omaha, NE 68154 Phone: 402-317-5276
Fax: 402-951-9730