CLIENT INSURANCE INFORMATION SHEET

Dr. Lisa Aimee Thompson CRC., LPC.
34 East Center Street, Suite 22/23
Fayetteville, AR 72701
479-935-5430

_____
_____

First Name _____MI _____Last Name_____

Address

_____
_____

City _____State _____Zip _____

E-mail_____

Home Phone _____Cell Phone_____

SSN _____ Occupation _____

Date of Birth _____

(circle one) Employed Full Time / Not Employed / FT Student/ PT Student

(circle one) Married / Single

Insurance: _____COPAY or Payment Amount: _____

ID Number _____

Group Number _____

Relationship to insured (circle one): Self / Spouse / Child / Other

If relationship to insured is other than self:

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Name and address of insured

_____

Birth Date of insured _____

Gender of insured: Male / Female

**How do you prefer to be contacted for scheduling and billing? (circle one)

TEXT / CALL / EMAIL

**Method of payment (circle one): Pay at session / Bill Credit Card / Other

_____

_____

AUTOMATED CREDIT CARD PERMISSION FORM

Date: _____

Name of patient:

_____

Name of the person on the credit card:

_____

Credit card number:

_____

Discover: _____ MasterCard: _____ Visa: _____ Amex _____

Expiration date on card _____ CVV Code on (back of card) _____

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Billing address on credit card:

_____

(Street address)

_____

(City, State)

_____

(Zip code)

<u>*Option 1</u>

*FOR ONE TIME CHARGE : I give Lisa A. Thompson's office permission to charge
$_____
on the above credit card.

<u>OR</u>

<u>*Option 2</u>

*FOR REPEATED CHARGES : I give Lisa A. Thompson's office permission to charge

$ _____

on the above credit card after each date of service is rendered.

_____
Signature of person on card

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.
PLEASE RETURN THIS FORM TO LISA A. THOMPSON or by e-mailing it to
murphy-thompson@att.net