

**KATHY HIGGINS LPC LLC**

**Kathleen Higgins MS, MA, LPC, LAC, EMDR, NCC**

5912 S. Cody St., Suite 302

Littleton, CO 80123

720-663-7702

**Client Information Form**

<b>Client Name:</b>	<b>Date of Birth &amp; Social Security #:</b>
<b>Street Address:</b>	<b>City/State/Zip:</b>
<b>Home Phone:</b>	<b>Messages okay? Y or N</b>
<b>Work Phone:</b>	<b>Messages okay? Y or N</b>
<b>Other Phone:</b>	<b>Messages okay? Y or N</b>

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<b>Primary Insured:</b>	<b>Relation to Client:</b>
<b>Employer:</b>	<b>Date of Birth:</b>
<b>Street Address:</b>	<b>City/State/Zip:</b>
<b>Primary Insured's Social Security #:</b>	

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<b>Primary Insurance:</b>	<b>Phone#:</b>
<b>Visits Authorized:</b>	<b>Copay:</b>
<b>Member ID#:</b>	<b>Group Number:</b>
<b>Authorization #:</b>	<b>Client Number:</b>

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By signing below, I agree to the following: (1) I understand that the client is ultimately responsible for the cost of all services rendered. (2) As a service to me, Kathy Higgins may bill my insurance company on my behalf. However, I am responsible for verifying insurance coverage and obtaining any necessary pre-authorization. If I fail to do so, I will pay the provider's full customary fees for all services rendered. (3) I authorize the release of any information necessary to process insurance claims (4) I authorize my insurance company to pay Kathy Higgins directly for the services provided to the client. (5) I will pay the appropriate co-payment or co-insurance to the provider at the time service is rendered. (6) I understand that I will be billed for missed appointments that are not canceled at least 24 hours in advance and that I am responsible for paying those charges.

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**Signature of client/guardian**

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**Date**