THOMAS L. FUSCO, LCPC
OFFICE: 8 Stanwood Street Brunswick, ME 04011 **Tel. 207-841-8640**

Client's Name: _____ Intake Date: _____

Address: _____ Town:_____ State/Zip:_____

DOB: _____ SS#: _____ Gender: M F Married:___ Single:___ Other:___

Home Phone:_____ Cell:_____ Work:_____

PAYOR INFORMATION

Primary Insurance Company:_____ Policy #:_____

Subscriber:_____

Address of Insurance Co:_____

Secondary Insurance Company:_____ Policy #:_____

Subscriber:_____

Address of Insurance Co:_____

CLIENT INFORMATION

Emergency Contact:_____ Tel #:_____

Address:_____

Who is responsible for the bill?:_____ Address:_____

Primary Health Care Provider:_____

Address:_____

Phone:_____

BILLING INFORMATION

Referring Doctor:_____ Referral Obtained?: Y_____ N_____

Valid Referral Number:_____ Starte:_____ Expiration:_____

DSM/ICD10 Code:_____ Total # of Sessions Allowed:_____

Signature on file information:
___I underestand that my services will be billed at $130.00 per hour.
___I understand that payment is expected at the time of service.
___I understand that I am responsible for any appointments that I miss without giving 24 hour notice.
___I understand that I am responsible for my bill if my insurance company does not pay.
___I understsnd that no paper work or reports will be sent out if my bill is not paid.
___I authorize payment directly to my therapist.
___I have ssigned the Notice of Practice of Thomas L. Fusco,LCPC
___I will permit a copy of this authorization to be used in place of the orginal.
___I understand that there is NO smoking in or on the property.

I HAVE READ THIS FORM AND UNDERSTAND IT'S CONTENTS

SIGNATURE:_____ DATE:_____

PARENT/GARDIAN (IF MINOR):_____ DATE:_____

CLINICIAN:_____ DATE:_____