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

PATIENT INFORMATION

Name:
Date of Birth:
Address:
City/ST/ZIP:
Employer:
Occupation:

Home Phone:
Cell Phone:
Work Phone:
Social Security #:
Male_____ Female_____
Who referred you?

BILLING INFORMATION

Name:
Date of Birth:
Address:
City/ST/ZIP:
Employer:
Occupation:

Home Phone:
Cell Phone:
Work Phone:
Social Security #:
Male_____ Female_____

INSURANCE INFORMATION

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

SECONDARY INSURANCE CARRIER
Company:
Address:
City/ST/ZIP:
Phone#:
ID or Subscriber #:
Group #:
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