Laura Doughty, MS, LMHC

109 East Third Avenue, Suite 7 Ellensburg, WA 98926
Phone: (509) 925-2258 Fax: (509) 925-2008
www.counselingellensburg.com

Registration Information

Client Name: _____ Date of Birth: _____

Home Address: _____City/State/Zip_____

Email: _____ Phone: _____

If we need to change an appointment, you will be contacted by phone. May we leave a voice message? □ Yes □ No

Emergency Contact:

_____

Name Phone Number Relationship to Client

Primary Insurance/Responsible Party

Primary Insurance Company_____

Copay $_____ *Deductible $_____ Co-Insurance $_____

Billing full name: _____

Relationship to Client: _____ Date of Birth: _____

Billing Address:_____City/State/Zip_____

Email Address: _____Ok to send receipts/statements via email? ☐ Yes ☐ No

Billing Phone: _____ Ok to leave message? ☐ Yes ☐ No

Secondary Insurance/Responsible Party (if any)

Secondary Insurance Company_____

Copay $_____ *Deductible $_____ Co-Insurance $_____

Billing full name: _____

Relationship to Client: _____ Date of Birth: _____

Billing Address:_____City/State/Zip_____

Email Address: _____Ok to send receipts/statements via email? ☐ Yes ☐ No

Billing Phone: _____ Ok to leave message? ☐ Yes ☐ No

*** Policies with a DEDUCTIBLE REQUIRE a non-HSA credit card on file. Any balance remaining after an insurance claim has been completed will be charged to this card. You may elect to pay with a check or cash at the time of your appointment to avoid charges being made to your credit card. Any client may elect to have balances unpaid by insurance charged to their credit card by completing the following information.**

I hereby consent to charge my credit card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my insurance carrier determines as payable by me. ☐ Visa ☐ Mastercard ☐ Discover

Card Number:_____ Exp. Date:_____ CVV Code:_____

Card Holder Name: _____

Card Holder Billing Address:_____ City/State/Zip_____

Card Holder Signature: _____ Date: _____

Email Address: _____Ok to send receipts/statements via email? ☐ Yes ☐ No

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Private Pay: **Payment is due in full at the time of service**.
Payment at the time of service may be made by check, cash, or credit card. Completing the information below allows you to have your non-HSA credit card charged each time you come in.

I hereby consent for the office of Laura Doughty, MS, LMHC to charge my credit card for all charges associated with receiving services provided by her. Typical services included: Initial Intake Appointment $175/session; Individual Counseling (50 min) $130/session; Individual Counseling (55+ min) $175/session. Actual fees charged depend on service code associated with the session.

☐ Visa ☐ Mastercard ☐ Discover

Card Number:_____ Exp. Date:_____ CVV Code:_____

Card Holder Name: _____

Card Holder Billing Address:_____ City/State/Zip_____

Card Holder Signature: _____ Date: _____

Email Address: _____Ok to send receipts/statements via email? ☐ Yes ☐ No

Please send monthly statements that may be used to submit a claim for reimbursement to my insurance company to: ☐ the address above, or ☐ the email above.

Missed Appointments:
I am financially responsible for my attendance at scheduled appointments. A charge of $55 will be applied to my account for a no-show or cancellation with less than 24 hours in advance. This charge is **NOT** covered by insurance.

Insurance Billing:
I authorize Laura Doughty, MS, LMHC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Laura Doughty, MS, LMHC. I understand that I am responsible for payment for serviced rendered by Laura Doughty, MS, LMHC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify Laura Doughty, MS, LMHC immediately whenever I have changes in my health plan coverage.

Account Responsibility:
I am responsible for payment to Laura Doughty, MS, LMHC for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, Laura Doughty, MS, LMHC reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names Laura Doughty, MS, LMHC as a creditor in any bankruptcy filing.

Termination of Counseling:
I agree that when I chose to end the counseling relationship, I will discuss this with my counselor. If I miss an appointment I will contact Laura Doughty, MS, LMHC to confirm whether additional appointments are wanted. After a second missed appointment, if there is no request for further appointments, the counseling relationship is terminated.

I have read and agree to all terms presented herein:

Client Signature: _____ Date: _____