Wendy J. Klein, MSW, LCSW, LLC
Individual and Family Psychotherapy Services
(303) 204-0489

4770 E. Iliff Ave, Suite 115
Denver, CO 80222

Client Information

Name_____Date_____

Address_____

City _____State _____Zip_____

Birth Date:_____Social Security #:_____

Occupation _____Employer_____

Phone Numbers where I may reach you and leave a message if necessary:

_____

_____

Referred by _____

_____

Email Address:

_____

Current Medications (include herbal and/or homeopathic)

_____

Medical Conditions

_____

_____

Primary Care Provider/Other Medical Providers Phone Numbers

_____

Emergency Contact:

Name:_____Relationship:_____

Street Address, City,
Zip:_____Phone:_____
_____

Responsible Party for Payment:

Name:_____ Relationship:_____

Street Address, City,
Zip:_____
Phone:_____

Primary Insurance Plan:

Name of Company:_____ Phone:_____

Address for Claims:_____

Name of Insured:_____ Birth
Date:_____ Group Number or Name:_____

Policy Number:_____ Co-Pay:_____

Deductible:_____ Deductible Left:_____

Yearly Max:_____

Primary Care Physician: _____
Phone:_____Address:_____

We do not bill secondary insurance, so you must collect on your own if you have a secondary plan.

PATIENT & INSURANCE DATA SHEET

(Insurance Verification of Benefits)

Practice/Physician Name:

Wendy J. Klein, LCSW

Date:

Patient Information

Name: _____

Address: _____

City: _____ State: Colorac Zip: _____

SS#: _____

DOB: _____ Sex: _____

Telephone: _____

Email: _____

Current Employer:

_____

Prescribing/Referring Physician: *(if applicable)*

_____

Diagnoses/ICD-10: _____

_____

CPT Code(s): _____

_____

Referring NPI #: _____

Phone #: _____

# of visits prescribed by doctor: _____

Notes: _____

_____

_____

Insurance Information

Name of Insured (if different than patient):

_____

SS#: _____ DOB: _____

Telephone: _____

Relationship to patient: Other

Insurance Co: _____

Claims Address: _____

_____

City: _____ State: Colora Zip: _____

Plan Name: _____

Insurer's ID #: _____

Policy/Group #: _____

Claim or Case #: _____

Adjuster: _____

Ph #: _____ Fax #: _____

# of visits authorized by ins co: _____

Co-Pay: _____ Deductible: _____

$ of Ded. Met: _____ Co-Ins Amt: _____

OOP: _____ OOP Met: _____

Covers: _____

_____

Eff. Date of Policy: _____

_____

All payments must be authorized with the insurance carrier prior to any treatment being completed and/or any billing being submitted for treatment. Any lapse in payment by the insurance carrier will become the full responsibility of the patient and/or guarantor. **** Required Information highlighted in yellow**