

Denise M. Searce, MSW, LCSW
Licensed Clinical Social Worker
7032 Wrightsville Ave., Suite 103-B
Wilmington, North Carolina, 28403
Bus Phone: 910-256-6163

Home Phone: _____ Date: _____

Patient _____

Last Name First MI

Street Address _____

City: _____ State _____ Zip Code: _____

If Children: Parents Names _____

School: _____ Grade: _____

Birth date: _____ Age: _____ Sex: M F Marital Status _____

Patient or Parent employed by: _____

Business Address: _____

Business Phone: _____

Spouse employment: _____

Business Phone: _____ Patient SS# _____ Spouse SS# _____

Do you have Insurance? Yes No Please submit your card to copy.

Referred by: _____

ASSIGNMENT OF BENEFITS

I the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I acknowledge that my signature on this document authorizes my therapist to submit claims for benefits or services rendered without obtaining my signature on each claim, and that I will be bound by this signature as though I had personally signed the claim.

I, _____ (name of insured) hereby authorize (Ins. Co.) _____

To pay and hereby assign directly to Denise M. Searce, MSW, LCSW all benefits, if any, payable to me for services as described on the attached form. I understand I am financially responsible for all charges incurred.

Authorized signature of subscriber

Date

CONSENT TO RECEIVE TREATMENT

Please read carefully and sign.

1. I understand the business policies of Denise M. Searce, MSW, LCSW.
2. I consent to receive treatment and understand that I am financially responsible for services rendered.
3. If insurance is to be billed, I will provide my insurance card and information and will meet any deductible. I will pay any co-payment in full at each visit.
4. I will pay the charges for appointments I do not cancel by 5:00 P.M. on the last day before an appointment.

Signed _____

Date _____

Parental Consent (Must be signed if client is a child)

I, _____ do hereby certify that I have legal custody of am the legal guardian for medical consent purposes of _____ (Child's name)

I, _____ give my permission for him/her to receive mental health treatment of evaluation.

Parent/guardian

witness

Date

Date

Appointments:

Initial Session 50-60 min

Family therapy: 50 min

According to CPT IV, the following procedures are billable contract and treated as such: TELEPHONE CONSULTATIONS, COLLATERAL CONTACTS WITH RELEVANT AGENCIES, WRITTEN REPORTS CONCERNING DIAGNOSIS AND TREATMENT OF A PATIENT. All of the above are billed according to time involved. Charges not covered by third party insurers are the responsibility of the patient.

Fees vary per MD, Ph.D, Psy.D, and MSW