Kristy Crump, LCPC, NCC
336 S Main Street Suite 1-D Bel Air, MD 21014
443-502-0714

CLIENT INFORMATION FORM

Patient Name (Last-First-Middle) _____
Date of Birth_____ Age _____ Sex _____
Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Responsible Party if Minor _____Spouse if Married_____

Home Address - Street _____
City _____ State _____ Zip_____
Home Phone _____ Cell Phone _____
Permission to leave a message Yes _____ No _____ Referred by _____

Email Address _____
Preferred method of appointment reminders: Phone_____ Text _____ Email_____

Family Doctor _____Address _____

Emergency Contact Name _____ Phone _____

I consent to the treatment of (Minor's Name) _____

Parent/Guardian Signature _____

INSURANCE INFORMATION

Primary Insurance Company Name _____
Employer _____
Policy ID Number _____ Group Number _____
Phone _____ Effective date _____
Name of Insured _____ Insured D.O.B. _____
Insured Address_____
Insured Phone Number_____ Relationship to Patient _____
Did you obtain preauthorization? _____
Deductible Amount $_____ Copay $ _____

*I understand and agree that regardless of our insurance status, I am ultimately responsible for payment of any professional services rendered and for any outstanding account balances. I certify the above information is correct to the best of my knowledge. I will notify you of any changes in insurance status. I further understand that any copay or coinsurance amount is due at the time of visit. If you do not have insurance, payment is expected at time service is rendered.

Kristy Crump, LCPC, NCC is authorized to release any pertinent information to my insurance company as required to obtain payment for services provided.

I hereby authorize payment of any medical benefits to Kristy Crump, LCPC, NCC by the above identified insurance company for services rendered.

_____ _____
Signature Date