Karen Chambre, LCSW, BCD
4920 Van Nuys Blvd #309
Phone (818) 509-1732~

Billing Sheet

Please complete this form and email it to: wardchambre@gmail.com

Name: _____
Last First Mi AGE
Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) (__) _____ Cell: (___) _____

DOB: ____/____/_____ M / F SS#: ___-____-____ Marital Status: _____

Employer: _____ Phone: (W)_____

RESPONSIBLE PARTY INFORMATION (Person who is financially responsible for account)
Name: _____
First Mi Last

Address_____
City: _____ State: _____ Zip_____:
Phone: (H) (_____) _____ Cell: (_____) _____
DOB: ____/____/_____ M / F SS#: _____ Marital Status:
Employer: _____ Phone: (W) (____) _____
INSURANCE INFORMATION Champus Authorization
Number_____

Primary Ins: _____ Phone # for mental health: (_____) _____

Subscriber name: _____ SS#: _____ DOB:
____/____/_____
Relationship to client: _____ ID/Membership #: _____ Group #:
_____
Secondary Ins: _____ Phone # for mental health:
(_____)_____
Subscriber name: _____ SS#: _____ DOB:
____/____/_____
Relationship to client: _____ ID/Membership #: _____ Group #:
_____

I hereby authorize Karen Chambre, LCSW, to release any information requested by Reliable MH Billing Services that is needed to bill the above named insurance companies and/or client directly. I hereby authorize Karen Chambre, LCSW, to
release any information requested by the above named insurance companies that is needed for claim processing. I hereby authorize the above named insurance companies to pay directly to Karen Chambre, LCSW, any insurance benefits.

Signature _____Date _____

K aren Chambre, LCSW, BCD
4920 Van Nuys Blvd #309
Sherman Oaks, CA 91403 -
Phone (818) 509-1732

Information Sheet

Your Name _____

Your Address _____

City _____ Zip _____

Home # ____ - ____ - _____ Business # ____ - ____ - _____ Cell # ____ - ____ -_____

E-mail address_____Occupation _____

Place of Business _____

Social Security Number _____ -- _____ -- _____ Date of Birth ____ / ____ / ____

Please list the persons living in your household

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I was referred by: _____

Do you have any health problems? If so, please explain: _____

_____

Please list any medications you are currently taking: _____

_____

How often do you use drugs or alcohol? _____

All information disclosed to the therapist will be held as confidential. Confidentiality, however, does not extend to bodily harm to self or others, or the abuse of a child. I understand that in the above instances the therapist is required by law to report the situation to the appropriate authorities. Payment is due at the end of each session. If payment is not received at the end of the session, I understand that I will be billed monthly. (Prompt payment is greatly appreciated.)

By signing below, I acknowledge the 24-hour cancellation policy which states: if an appointment needs to be rescheduled or canceled, I will notify this office 24-hours in advance (emergencies, illnesses are the exemption.) I understand that missed appointments cannot be charged to the insurance company and, if a 24-hour notice is not provided, I understand that I will be personally responsible for the charges of the missed session.

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Hippa Form

Release of Information

I authorize the release of information for claims, certifications/case management/quality improvement, and other purposes related to benefits of my Health Plan I authorize my Health Plan to pay my therapist directly for treatment.

Initial here, or write “not authorized” if you do not want your insurance billed:

_____

Consent for Treatment

I authorize and request my therapist to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures that now, or during the course of my treatment become advisable. I understand the

purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

Patient Signature Date

_____ _____