RONALD J. EASTMAN, M.ED., LMHC, CGP
EASTMAN COUNSELING SERVICES
ACCOUNT INFORMATION

Client's Name____Age__________Date of Birth______________________

Address____(City/Zip)________________________________

Employer____ Male__________ Female_______

Phone (H)_________________________Phone (Cell)______________________Phone (W)________________________

Can we call? Home :Yes [ ] No [ ] Cell :Yes [ ] No [ ] Work :Yes [ ] No [ ]

Client SS No.:____Date First Seen :__________________________

PRIMARY INSURANCE INFORMATION

Subscriber____Date of Birth______________________

SS No.___________________________Group No.________________________Policy No.________________________

Subscriber's Employer____Phone No.________________________

Primary Insurance Co., & Mailing Address for Claims____

____Phone No.________________________

Insurance Co. pays/visit____________________Per Year___________________Co-Pay/Amt______________________

Contract Year from_________________________to__________________Deductible_______________________________

If someone other than the client is responsible for payment, please complete this section:

____Relationship to client______________________
(Name)

Address____Phone No.________________________

Social Security Number:__________________________________

ASSIGNMENT OF BENEFITS

**I authorize the release of information necessary to process this claim. I assign all medical benefits to which I am entitled to be paid directly to Eastman Counseling Services and/or Ronald J. Eastman, M.Ed.
A photocopy of this assignment is to be considered as the original.**

I understand that I will be charged for missed appointments ("no show") and for those cancelled with less than 24-hour notice. Additionally any check returned for non-sufficient funds will accrue a $35.00 fee.

Client: Signature:____ Date____________________

Print: ____
(Parent/Guardian if client is a minor)