Hicks Counseling Services
Beverly Hicks, M.Ed.
NC: LCMHC, CCS, CADC
TX: LMFT, LCDC

Mailing Address
9650 Strickland Rd. Suite 103-424
Raleigh, NC 27615

Office: 919.904.4257
Fax: 866.594.1848
www.hickscounseling.com

GENERAL INFORMATION FORM

Last Name: _____ First: _____ MI: ___ Nickname: _____

Sex: M F SS#: _____ DOB: _____

Home#: _____ Cell#: _____ Email: _____

Street: _____ City: _____ State: ___ Zip: _____

Married __ Single __ Separated __ Divorced __ Widowed __ Under 18 years of age? Yes ___ No ___

If under 18… Mother's Name: _____ Cell#: _____

Father's Name: _____ Cell#: _____

Name of Responsible Party Covering Deductibles and Co-pays: _____

Same address as above? Yes ___ No ___

If not, Street: _____ City: _____ State: ___ Zip: _____

Primary Care Physician's Name: _____ Phone: _____

Current Medications: _____

Primary Insurance Coverage - PLEASE DO NOT LEAVE ANY BLANKS

Insurance Co: _____ Tel#: _____

Claims: Street: _____ City: _____ State: ___ Zip: _____

Policy#: _____ Group#: _____

**Please present your card to therapist to be photocopied

Mental Heath Insurance Coverage If Applicable - PLEASE DO NOT LEAVE ANY BLANKS

Insurance Co.: _____ Tel#: _____

Claims: Street: _____ City: _____ State: ___ Zip: _____

Policy#: _____ Group#: _____

Is pre-certification necessary? Yes ___ No ____

If Yes, Authorization #:_____# of visits: _____ Start Date: _____ End Date: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign payment directly to entity named above all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance. I am entitled to a copy of this agreement by requesting one.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**