Today's Date: _____

Chambers & Blohm Psychological Services, P.C.
309 North Mandan Street – Suite #1
Bismarck, ND 58501
(701) 323-0924

Client's Name: _____ MALE FEMALE OTHER ☐
First MI Last

Date of Birth: _____/_____/_____

Address: _____
Street Address City State Zip Code

Social Security # _____ Responsible Party _____

Address: _____

Home Telephone Number: _____ Cell Phone Number: _____

Email Address: _____

Client's Employer / School: _____ Employer's Telephone Number: _____

Spouse's Name: _____ Employer _____ Employer's Telephone Number: _____

If Child: Father's Name: _____ Employer _____ Employer's Telephone Number: _____

Mother's Name: _____ Employer _____ Employer's Telephone Number: _____

Primary Care Physician: _____

Emergency Contact:

Name _____ Relationship _____

Address _____ Telephone _____

INSURANCE: ***Please check the appropriate insurance and complete its designated section.***

***** Please note: You, the client is responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify services before services are rendered..***

Medicare: Medicare Number: _____

BCBS Policyholder _____ Date of Birth: _____
(Name on Card) (of PolicyHolder)

Policy Number _____

Other Insurance: Company Name and Address _____

Policy Holder _____
Name and Date of Birth

Policy Number _____ Group Number _____

Medicaid: Medicaid Number: _____ County: _____

Self Pay ***(please note: It is required that self-pay clients must pay for services <u>prior</u> to the services being rendered)***

Authorization: I hereby authorize Chambers & Blohm Psychological Services, P.C. to furnish information to insurance carriers concerning any services rendered to me or any member of my family, and I hereby assign to Chambers & Blohm Psychological Services, P.C. all payments for services rendered. I understand that I am financially responsible for all charges. ***** Please note: You, the client is responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify services before services are rendered.***

Signed: _____ Date: _____