Judith Belmont, MS, LPC
1011 Brookside Rd.
Suite 302
Allentown, PA 18106

Client Information

Name:____

Address: ____

____

Phone: Home _________________________ Cell _____________________________

Which number can I leave messages? Check one or both: ________ HOME ________ CELL

Email that I have permission to leave messages: ____________________________________

Date of Birth: _________________________

Reason for seeking help: ____

Previous Counseling Experience (Approx. Dates and Providers):

____

Current Psychiatric Medications ____

Insurance Information

Insurance Carrier ____

Identification Number ____

Group number or other information on card ____

Copay for Mental Health (usually under SP or Specialist) _________________________________

Has your deductible been met? If not sure, please call to verify with insurance carrier _____________

Primary Insured's Name ____________________ Birthdate: _________________________

Insured's address (if different than address for client) ___________________________________

Primary Insured's Employer ____

I authorize Judith Belmont, MS to submit insurance claims on my behalf with the information above with a diagnosis as me as the identified patient. I am responsible for paying copays and unmet deductibles. I understand I will need to give 24 hour notice for cancellations.

____ _______________________

Signature Date