Michele Lane LCSW
6300 W. Loop South #215
Bellaire, TX 77401
713-364-3256

Please complete all pages including claim form for insurance. All your information is CONFIDENTIAL!!! Kindly have check to Michele Lane ready before session. Thank you

Patient Name_____Insured Name_____SSN#_____
D.O.B._____age____Insured DOB_____ Employer_____
Co-payment_____Group#_____Deductible_____
Home Address_____
Home phone_____work_____cell_____e-mail_____
Couple's Spouse/Partner
name_____DOB____age____Home#_____wk#_____
#years married____, Living together__

Patient-divorced-#times____, years____, separated #times____, years____

Previous Counseling_? yes____no____, when_____. with whom_____
How did you find Michele Lane LCSW? provider directory____, Dr___, friend___
Website _____, referred by managed care/EAP _____

All fees and or co-payments are payable in advance. I understand that if my insurance company does not reimburse Michele Lane for each session of psychotherapy, I will be responsible for all unpaid sessions.

Signature_____ Date _____

Sign if using health insurance: I authorize the release of medical information or other information necessary to process this claim.

Signature_____ Date _____

I understand that if I am to cancel an appointment, I must give Michele Lane at least **24 hours** notice in advance. Otherwise I will be charged $60 for each session missed without advanced notice. Signature_____

(optional) I authorize release of information to my Doctor_____who is located at _____ telephone_____. Signature_____