# NEW CLIENT FORM

**Mosaic Psychological Center, PLLC**
**5970 Fairview Road, Suite 414**
**Charlotte, North Carolina 28210**

**Patient Information**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work/Other Phone: _____ Email: _____

Date of Birth: _____ Social Security No.: _____

Marital Status: Single _____ Married _____ Other _____ Gender _____

Employment Status: Employed _____ Student _____ SAHM _____ Retired _____ Other _____

Employer or School: _____

If adolescent, list siblings' names and ages here: _____

**Primary Insured's Information**

Patient's Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

(If patient relationship to insured is "self," skip this section. If adolescent, list both parents here.)

Father

Name: _____

Address: _____

City: _____State: _____

Zip: _____ Phone: _____

Mother

Name: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Insured's Date of Birth: _____

Insured's Social Security No.: _____

Insured's Employer: _____

**Primary Insurance Company Information**

Insurance Company Name: _____

Policy Number: _____ Plan Name: _____

Group Number: _____ Employer or School Name: _____

In case of emergency, who should be notified: _____ Phone: _____

Primary Care Physician: _____ Referred by: _____

The undersigned have insurance coverage with _____and assign directly to Mosaic Psychological Center, PLLC all medical
(Name of Insurance Co.)
benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize Mosaic Psychological Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and updates. I understand that a charge is made for missed appointments not cancelled 24 hours in advance or 48 hours in advance for Monday appointments**. I will be charged $80 for the first miss and $165 for any subsequent misses not due to illness or emergency.** I understand I need to keep an active credit card on file and that the missed fee will be automatically billed by the end of that business day. If I contest the charge(s) and a chargeback occurs, I understand I will be responsible for that cost.

Signature of Insured/Guardian

Today's Date