

## CLIENT INFORMATION

Today's Date: \_\_\_ - \_\_\_ - \_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Marital Status (circle one) M S D W Sex: M F

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Referred by: \_\_\_\_\_

Where can we contact you in case of emergency? Phone: ( ) \_\_\_\_\_

### Responsible Party Information (Required if filling out for a minor)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

### Insurance Information (Please fill out completely if we are to file insurance)

Primary Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security #: \_\_\_ - \_\_\_ - \_\_\_

### Assignment of Benefits

I hereby authorize my insurance company to pay the clinician directly for benefits due me for his/her services. I also authorize the release of any information to my insurance carrier. I also understand that at the time of service, I am responsible for paying either my primary co-payment or a minimum co-payment of \$25.00. I understand that I am responsible for payment of any and all charges for services rendered. If payments have not been received on my account within 90 days, I must call to make payment arrangements. If I do not call or do not adhere to my plan, I understand that my account may be turned over to a collection agency.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_