ADULT CLIENT INFORMATION FORM

Failure to complete this form in full can lead to difficulties receiving payments from insurance companies.

Clients Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____Circle One: Male Female SS#:_____

Home Address: _____ City & Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

May I contact you via E-mail if needed? If so, list E-mail address: _____

Marital Status: _____ Employed □ Full-time Student □ Part-time Student □

Employer: _____ Occupation: _____

Primary Care Physician: _____Phone: _____

Spouse/Partner's Name: _____Birth date: _____

Spouse/Partner's Employer: _____Occupation:_____

Other Adults in the home: _____ Relationship to Client: _____

Children in the home and their ages: _____

Have you previously been seen by a therapist? If so, who? _____

By who were you referred? _____

Client Release (Optional)

"I authorize the release of information to my primary care physician, psychiatrist, and/or OB/GYN for the purpose of coordinating my health care**."** **(Initial)** Yes_____ No _____

Insurance Information/Responsible Party Information

Full Name of Insured/Responsible Party _____SS#: _____Male/Female

Home Address (if different): _____City & Zip: _____

Relationship to Client: _____ Employer's Name: _____

Primary Insurance: _____ Primary Insurance Phone#: _____

Claims Address (include city, state & zip):_____

I.D.#: _____ Policy or Group #: _____

Deductible: _____ Met? Y /N Co-pay:_____ Type of Insurance: HMO PPO POS

***Authorization Needed? Yes/ No Obtained? Yes/ No Auth #: _____**

***Pre-authorizations are the responsibility of the client/responsible party**

"I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my health plan. I understand that my Health Plan is to supply me with a confidentiality of Personal and Health Information packet. I also understand that my Health Plan is reimbursing the cost of therapy based on an acceptable diagnosis sent to them by the provider". (Initial) Yes_____ No _____

OFFICE BILLING AND INSURANCE POLICY

By my signature below: I understand that it is my responsibility to be aware of the limits of my insurance coverage. I authorize the use of this form on all insurance submissions. I authorize the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I understand that I, not my insurance company, am responsible for and will be billed for any appointments which I cancel or miss with less than 24 hours notice to the service provider. I authorize direct payment to my service provider. Client billing is usually completed at the beginning of each month and the balance is due upon receipt. ***Copays are due at each session.***
I hereby permit a copy of this form to be used in place of the original.

Signature: _____ Date: _____