

PATIENT INFORMATION

(BOLD INFO. IS REQUIRED THROUGHOUT FORM)

Patient Name: _____ E-mail: _____

Patient Address: _____ City: _____ St: _____ Zip+4: _____ - _____

Home Phone: _____ Sex: M F Student: FT PT No Where: _____

May we leave a message on your home phone? Yes No Marital Status: S M D W Other _____

Work Status: FT PT Retired Self-Emp Not Emp Birthdate: _____

Work Phone: _____ Social Security #: _____

GUARANTOR/FINANCIALLY RESPONSIBLE PERSON(S), (if different from client)

PRIMARY Responsible: _____ Relationship to patient: _____

Address: _____ City: _____ St: _____ Zip+4: _____ - _____

Home Phone: _____ Sex: M F Date of Birth: _____

Work Phone: _____ Social Security #: _____

% OR AMOUNT to be applied to PRIMARY GUARANTOR _____

SECONDARY Responsible: _____ Relationship to patient: _____

Address: _____ City: _____ St: _____ Zip+4: _____ - _____

Home Phone: _____ Sex: M F Date of Birth: _____

Work Phone: _____ Social Security #: _____

% OR AMOUNT to be applied to SECONDARY GUARANTOR _____

EMERGENCY CONTACT INFORMATION

Name of Contact: _____ Address: _____

Day Phone: _____ Evening Phone: _____

Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION (If Applicable)

Primary Insurance Company: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

ID Number: _____ Group Number: _____ Policy Holder: Self Spouse Child

Policy Holder Name (if different than client): _____ DOB: _____

Policy Holder Address (if different than client): _____ City: _____

State: _____ Zip+4: _____ - _____ Employer: _____

New Client Information Form

SECONDARY INSURANCE INFORMATION (if Applicable)

Secondary Insurance Company: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

ID Number: _____ Group Number: _____ Policy Holder: Self Spouse Child

Policy Holder Name (if different than client): _____ DOB: _____

Policy Holder Address (if different than client): _____ City: _____

State: _____ Zip+4: _____ - _____ Employer: _____

REFERRAL SOURCE

Circle one:

Insurance EAP Program Friend/Family Phone book/internet Other: _____

Central College Church Physician: _____

Church (name): _____ Would you like us to contact your pastor? Circle one: Yes No

Church Address: _____ City: _____ St: _____ Zip: _____

Phone: _____

Physician (name): _____ Would you like us to contact your physician? Circle one: Yes No

Physician Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

AUTHORIZATION

I hereby authorize the release of any medical, mental health or other information necessary to process this claim. I also authorize payment of medical/mental health benefits to the provider or supplier for services rendered. I further agree that should the amount be insufficient to cover the entire services provided, I will be responsible to the provider for payment of the entire bill.

Signed: _____

Date: _____

FOR OFFICE USE ONLY

___ BENEFITS AUTHORIZED ___ HIPAA ___ FINANCIAL AGREEMENT ___ INSURANCE CARD