CLIENT INFORMATION FORM

********* Please Print *********

First Appointment: ______________________ Today's Date: ______________________

CLIENT INFORMATION:

Last Name: ______________________

First Name: ______________________ Middle Initial: ______

Address: ______________________

City: ______________________ State: ________ Zip Code: ________

Home Phone: ( ) ______________ Birth Date: ______________________

Cell Phone: ( ) ______________ Sex: Male ________ Female ________

Work Phone: ( ) ______________ Social Security #: ______________________

Ok to leave message at: ________ E-mail (apt. reminders) ______________________

Marital Status: Single ____ Married _____ Divorced ____ Widowed _____ Other ______

Employer: ______________________ Student: ______________________

In the event of an emergency AFC may contact: ______________________

Relationship: ______________________ at phone number ( ) ______________

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):

(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: ______________________

First Name: ______________________ Middle Initial: ______

Address: ______________________ City: ______________ State: ____ Zip Code: _______

Home Phone: ( ) ______________ Birth Date: ______________________

Cell Phone: ( ) ______________________ Sex: Male ______ Female _____

Work Phone: ( ) ______________________ Social Security # ______________________

Ok to leave message at: ______________________

PRIMARY INSURANCE INFORMATION:

(*__You must complete this section and present a copy of your insurance card for insurance to be billed__*)

Insurance Company: ____________________________ Phone Number: (   )_________________

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _________________________   Employer: __________________________

I.D. #: ______________________________________   Group #: ___________________________

Last Name: _________________________________

First Name: _________________________________   Middle Initial: ________

Address: ____________________________________

City: _____________________________________   State: ____________   Zip Code: _________

Home Phone: (   )________________________   Birth Date: ___________________________

Cell Phone: (   )__________________________   Sex: Male ________   Female _______

Work Phone: (   )__________________________   Social Security #: ___________________

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to Associates in Family Care. I understand that I am responsible for paying my deductible or co-pay (where applicable). Please Note: We will release information to Practice Management Solutions for the purposes of billing.

Signature ____   Date _______________

I authorize Associates in Family Care to release information to Practice Management Solutions for the purposes of billing.

Signature ____   Date _______________

I would like appointment reminders sent to me____Yes _____No : e-mail:__________________________

PLEASE NOTE: We __do not__ bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

This section must be completed by the Counselor/Coach/Advocate/CT BEFORE paperwork is processed

Counselor/Coach/Advocate/CT: _____________________________

Estimated amount due at time of service: $ _______________

Diagnosis 1: _____________________   **Diagnosis 2:** _____________________

Miscellaneous Information: ____

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