

WELCOME

The Center for Counseling
Your Life Is Precious.SM

CLIENT INFORMATION

Client: _____ Date _____

Sex ___M___F Birth date _____ Age _____ Minor Single Married Widow Separated Divorced

SS# _____ Address _____

Street City Zip

PHONE NUMBERS

Home _____ Cellular _____

What is your preferred method of contact? Home Cellular

May we send CFC information to your email? Y N e mail address _____

If Minor: Parents name: _____

Whom may we contact in the case of an emergency? Name _____

Relationship _____ Phone _____ Alternate # _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Client _____ Birthdate _____ SS# _____

Insurance Co _____ Contract # _____ Group# _____

Is client covered by additional insurance _____ Yes _____ No

Subscriber Name _____ Phone _____

Relationship to Client _____ Birthdate _____ SS# _____

Insurance Co _____ Contract # _____ Group# _____

I have reviewed and signed the Consent for Treatment form and voluntarily consent to participate in treatment.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Center for Counseling all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and that it is my responsibility to verify if The Center for Counseling is in network with my insurance company I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by my insurance company or pay the full client fee if I have no insurance coverage and to notify The Center for Counseling immediately if my insurance changes. Also, if The Center for Counseling is out-of-network, I am responsible for all charges. In the event that my insurance company does not pay within 120 days I am responsible for all charges and The Center for Counseling will provide receipts so that I may contact my insurance company. In the event that payment in full is not received within thirty(30) days, a service charge will be added to the outstanding balance, computed at the rate of one and a half (1.5%) percent per month. I hereby authorize The Center for Counseling to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client/Guardian Signature Relationship Date