

WELCOME

The Center for Counseling
Your Life Is Precious.SM

MINOR CLIENT INFORMATION (must be over 18 to complete form)

Client: _____ Date _____
Last First

Sex M F Birthdate _____ Age _____

SS# _____ Address _____
Street City Zip

PHONE NUMBERS

Home _____ Cellular _____

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

Father's Name _____ Birthdate _____ SS# _____

Mother's Name _____ Birthdate _____ SS# _____

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# _____

Whom may we thank for referring you to us? _____

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. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by y insurance company or pay the full client fee if I have no insurance coverage. 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 al information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client/Guardian Signature Relationship Date