WELCOME

The Center for Counseling
*Your Life Is Precious.*SM

CLIENT INFORMATION

Client: ____ Date ______________________
Last First

Sex __M __F Birth date _________Age ____ Minor Single Married Widow Separated Divorced

SS# ____________________ Address ____
Street City Zip

Preferred Language ________________________ Special Communication Needs ________________

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.

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Client/Guardian Signature Relationship Date