WELCOME

The Center for Counseling
Your Life Is Precious.℠

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

Client: ____ Date ______________________
Last First

Sex __M __F Birthdate _________Age ____

SS# ______________________ Address ____
Street City Zip

Preferred Language________________________ Special Communication Needs______________

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.

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Client/Guardian Signature Relationship Date