THERAPY FOR CHILDREN, ADULTS AND FAMILIES, INC.

CLIENT INFORMATION

YOUR NAME____ DATE OF BIRTH _________________

ADDRESS ____ CELL PHONE ___________________

CITY ________________ STATE ____ ZIP __________ SOCIAL SECURITY # ______-____-______

HOME PHONE ______________MARITAL STATUS _____ SEX ___ WORK PHONE ____________

NAME OF EMPLOYER____

IN CASE OF EMERGENCY NOTIFY _________________ RELATIONSHIP _______ PHONE#________

INSURANCE INFORMATION

INSURANCE COMPANY ____________________________ ADDRESS__________________________

CITY_________________________________ STATE _________ ZIP _________________________

PHONE NUMBER _____________________________ PAYOR ID# ____________________________

POLICY/ID# ______________________________________ GROUP #_________________________

INSURED'S NAME ____________________________ RELATIONSHIP TO YOU __________________

PRIMARY INSURED DATE OF BIRTH _______-________-________

PAYMENT POLICY

I UNDERSTAND THAT THIS OFFICE WILL BILL MY INSURANCE POLICY ON MY BEHALF; BUT I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED. I GUARANTEE PAYMENT OF ALL CHARGES, EVEN THOSE DENIED BY MY INSURANCE CARRIER. I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY DIRECTLY TO BRENDA HARTMAN, MSW, DBA THERAPY FOR CHILDREN, ADULTS AND FAMILIESL, INC. ALL BENEFITS ALLOWABLE AND PAYABLE UNDER MY CURRENT INSURANCE POLICY. I ALSO AUTHORIZE THE RELEASE OF ANY PERTINENT INFORMATION TO MY INSURANCE COMPANY.

____ ___________________________

SIGNATURE **DATE**