CLIENT INFORMATION

Please Print Legibly

CLIENT INFORMATION

Name _____ **Social Security #** _____-_____-_____ Sex: Male ___ Female ___
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone #_____ Work #_____

Age _____ **Date of Birth** _____ Single __ Married ____ Widowed___ Divorced ___ Separated _____

In case of emergency, who should be notified? _____ Phone _____

RESPONSIBLE PARTY/GUARANTOR OF PAYMENT

Name _____ **Social Security#** _____-_____-_____ **D.O.B** _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work _____

INSURANCE

Primary Insurance _____ Name of Policyholder _____

DOB Policy holder_____ **Social Security# of Policy holder**-_____-_____-_____

Policyholder Employer_____ ID number: _____

Insurance Company Address _____

Secondary Insurance _____ Name of Policyholder _____

DOB Policy Holder_____ **Social Security# of Policy holder**-_____-_____-_____

Policyholder Employer _____ ID number _____

Insurance Company Address: _____

ASSIGNMENT AND RELEASE

I, the undersigned, herby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my counselor to submit claims for benefits, services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that I am financially responsible for all charges whether or not paid by my insurance.

_____ _____
Signature of Responsible Party (Adult client or parent/guardian) Date Witness Date

(Revised 7/10/2019)