CHILD AND FAMILY SERVICES
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PATIENT INFORMATION

PATIENT'S FULL NAME:______________________________ TODAY'S DATE:______________

DATE OF BIRTH:______________ AGE:________ SEX:________ PATIENT SOCIAL SECURITY #:______________

CELL PHONE:______________ WORK PHONE:______________ HOME PHONE:______________

STREET ADDRESS:______________________________

CITY:______________________ STATE:______________ ZIP:______________

MARITAL STATUS: ____________ PATIENT'S EMPLOYER OR SCHOOL:______________________

GRADE:______________

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Beside the phone numbers listed above, please write 1, 2 and 3 next to the numbers we should use to confirm appointments, with number one being the best number.

(IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION)

Parent or Legal Guardian Names:

Name: ______________________

Relationship to patient: ______________________

Social Security Number: ______________________

DOB: ______________

Address: Same as above? ________ If no, complete:

____

____

Employer: ______________________

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

Email: ______________________

Number we can text?______________________

Name: ______________________

Relationship to patient: ______________________

Social Security Number: ______________________

DOB: ______________

Address: Same as above? ________ If no, complete:

____

____

Employer: ______________________

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

Email: ______________________

Number we can text?______________________

Is there a phone number at which we should not leave a message? If so which one?______________

INSURANCE INFORMATION

IMPORTANT: We need all medical insurance companies listed on this page. If you have one insurance that will not cover your visit here, but a secondary one that will, we are still required to file a claim to the first insurance before sending a claim to the second. Your second insurance will not pay without a reply from the first attached to our claim. Please ask one of our staff members for assistance if you have any questions when filling out this section.

#1

NAME OF INSURANCE____

POLICY HOLDER (NAME ON CARD)_______________________ POLICY HOLDER'S DATE OF BIRTH: __________

POLICY NUMBER_______________________________GROUP NUMBER______________________

EMPLOYER WHO PROVIDES THE INSURANCE____

#2

NAME OF INSURANCE____

POLICY HOLDER (NAME ON CARD)_______________________ POLICY HOLDER'S DATE OF BIRTH: __________

POLICY NUMBER_______________________________GROUP NUMBER______________________

EMPLOYER WHO PROVIDES THE INSURANCE____

Read below, sign and date if you approve:

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment (the clinician I will be seeing here).	I authorize payment of medical benefits to the clinician I will be seeing here for services he/she renders.
Signature of patient or authorized representative ________ Date ________	Signature of patient or authorized representative ________ Date ________

CHILD AND FAMILY SERVICES

ACKNOWLEDGEMENT, CONSENT, AND RELEASE SIGNATURES

PATIENT NAME:_________________________________ **DATE:**____________

Child and Family Agreement

I acknowledge that I have received a copy of Child and Family Services Psychologist/Counselor-Patient Agreement and agree to its terms and conditions.

____ _______________________

Signature Date

Receipt of Protected Health Information

I acknowledge that I have received a copy of the Policies on Protected Health Information from Child and Family Services.

____ _______________________

Signature Date

Listed below are the names of the individuals whom Child and Family may disclose any medical and/or financial information to on my behalf. These people are allowed to act as my personal representative.

Name:	**Relationship:**
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________

Financial Policy

We file insurance as a courtesy to our patients. Any charges accrued in this office are your responsibility regardless of insurance, pre authorization, or pre estimate amounts. You (not your insurance company) are responsible for full payment of all fees.

Your insurance company may not pay for your visits here if you see another mental health provider on the same day or week. If this occurs, you will be responsible for any charges not paid. Therefore, please do not schedule more than one mental health appointment per week.

Payment is due in full each visit.

There is a $35.00 fee on all returned checks.

If a appointment is missed without notice, or cancelled with a less than 24 hour notice you will be billed a $25.00 fee.*

Any unpaid balances after 90 days are subject to be turned over to a collection agency for payment which could result in collection fees and small court cost added to your account.

I have read, understand, and agree to pay for all services I receive at Child & Family Services.

________________________________ ______________

Signature of patient, parent or guardian Date

____

Patient Name (Print)

*Providers will comply with insurance requirements/agreement.