Client Information for the financial file

Client: _____ DOB: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Social Sec. Number: _____

Method of Payment: _____ Insurance _____ Sliding Fee _____ EAP

If Insurance, copay amount? _____ Sliding fee amount? _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Fees are due the date of services unless other arrangements have been made.

Responsible Party

Primary party: _____ DOB: __/__/__

Relationship to client: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Social Sec. Number: _____ _____ Male _____ Female

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

EAP? ___ Yes ___ No Authorization # _____

EAP Company Name: _____ Place of Employment_____

Primary Ins. Plan Name: _____

ID Number: _____ Group Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX Number: _____

Only if applicable:

Secondary party: _____ DOB: __/__/__

Address: _____Relationship to client: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Social Sec. Number: _____ ____ Male ____ Female

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Ins. Plan Name: _____

Insurance Company Name: _____

ID Number: _____ Group Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX Number: _____

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