CLIENT INFORMATION FORM

CLIENT'S NAME_____BIRTHDATE___/___/___

ADDRESS_____

CITY_____STATE_____ZIP_____

SOC SEC #_____PHONE_____CELL_____

MARRIED___ SINGLE___ PARTNER'S NAME_____

EMERGENCY CONTACT_____PHONE_____

PRESENTING PROBLEM FOR WHICH YOU SEEK HELP_____

_____

MEDICATION(s)? /DOSE _____

PHYSICIAN_____PHONE _____

EMPLOYED? ____BY? _____WK#_____

INSURANCE CO NAME_____

ADDRESS_____

CITY_____STATE____ ZIP_____PHONE_____

POLICYHOLDER'S NAME_____BIRTHDATE___/___/___

POLICY#_____Group #_____STARTED_____

I AUTHORIZE THE USE OF THIS FORM AND THE RELEASE OF INFORMATION TO CLINICAL BILLING SERVICES FOR ALL MY INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL. I'M AWARE A 24 HR NOTICE OF CANCELLATION MUST BE GIVEN OR $75.00 IS CHARGED. I'VE READ AND ACCEPT ALL THE CONDITIONS LISTED ON THE FINANCIAL TERMS FOR SEVICES RENDERED SHEET.

SIGNATURE_____ DATE_____