

**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 \$95.00 IS CHARGED. I'VE READ AND ACCEPT ALL THE CONDITIONS LISTED ON THE FINANCIAL TERMS FOR SEVICES RENDERED SHEET.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_