Fairhaven Counseling, Inc.
Client Details and Agreement

Complete entire form (front and back)

Today's Date: ____________

Client name: ____

Address: _____________________________________ City: ____________ Zip: ____________

Home phone: _____________________ Cell: __________________________

Social Security: ___________________________ Date of birth: _____________________

Sex: M / F Marital status: Single / Married / divorced / widowed

Emergency Contact: ______________________ Phone: ________________________________
Relationship to client: _______________________________________

Physician: ________________________________ Phone: _______________________
Physician address: ____

Employer/School: ____
Address: ____
Occupation: ____________________________________

Guarantor Information (party responsible for payment)
___ Check here if guarantor is the same as above
Name: __________________________ S.S.N:________________________
Address: _________________________________ Phone: ___________________________
City/State/Zip: ____________________________ D.O.B:___________________________
Relationship to client: _________________________
Insurance information:

Primary: Name of insurance co: ______________________________________
Name of Policy holder: _______________________________ D.O.B:_____________________
Policy #:____________________________________ Group: ___________________________
Relationship to client: ____________________________ S.S.N:______________________

Secondary: Name of insurance co: ______________________________________
Name of Policy holder: _______________________________ D.O.B:_____________________
Policy #:____________________________________ Group: ___________________________
Relationship to client: ____________________________ S.S.N:______________________

(Over)

****OFFICE USE ONLY****		
Counselor	DX CODE	Referred by

Authorization for release of information
I hearby authorize Fairhaven Counseling, Inc. to release such information in connection to my treatment to my insurance company(ies) for the purpose of processing the insurance claim.

Comprehensive Office Policy
I have read and understand the Fairhaven Counseling, Inc. office policy. I consent to Fairhaven Counseling, Inc.'s general procedures and billing practices. I authorize Fairhaven Counseling, Inc. to provide the necessary treatment. I understand that these policies may change with our without notice, but I am legally bound to the current policies as long as my or my dependent's treatment continues at this office.

Assignment of Insurance Benefits
I hereby authorize payment of the benefits otherwise payable to me by my insurance company(ies) directly to Fairhaven Counseling, Inc. The amount not to exceed regular charges.

Guarantee of Account
I understand that I am financially responsible for any changes not covered by my insruance company(ies)

Payment is expected at the time services are rendered.

____ ________________________
Client (parent or guardian if minor) Date