Client Information Form

Date: ____________________

<u>Client Information</u>

Name: ____

Address: ____

City: ____________________ State: __________ Zip code: __________

Phone Numbers: Home:__________________ Cell: __________________

Email Address: __________________________

Gender you identify as: ______________________

Date of Birth: ________________ Age: ______Marital Status: ____________

Employer: __________________________ Work Phone: ______________

<u>Responsible Party (Statements will be sent to):</u>

If different from above

Name: ____

Address: ____

City: ____________________ State: __________ Zip code: __________

Phone Numbers: Home:__________________ Cell: __________________

Email Address: __________________________

Date of Birth: ________________

Relationship to Client: ______________________

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.

AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: ______________________________ DATE: ______________

(Client or parent if patient is a minor)