|  |  |  |
| --- | --- | --- |
|  |  **Client Face Sheet** |  |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |   |
| Today’s Date |  | Client Name |
|  |  |  |
| Client Information |
|  |
| Address |
|  |  |  |  |  |
| City |  | State |  | Zip Code |
|  |
| Email Address  |
|  |  |  |
| Date of Birth |  | Responsible Party & Relationship |
|  |  |  |
| Home Phone |  | Cell Phone |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| --- |
| Insurance Information |
|  |
| Primary Insurance Company Name |
|  |  |  |
| Name of Insured (Subscriber) |  | Subscriber Date of Birth |
|  |  |  |
| Insurance ID Number |  | Group Number |
|  |
| Secondary Insurance Company Name |
|  |  |  |
| Name of Insured (Subscriber) |  | Subscriber Date of Birth |
|  |  |  |
| Insurance ID Number |  | Group Number |

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| *I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies. If it becomes necessary to effect collections of any amount owned, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |