NEW CLIENT INFORMATION

Therapist _____

Client Information

Name_____
First MI Last

Address_____Apt#_____

City_____ State_____ Zip_____

Telephone # _____ Cell phone #_____

Email: _____

Sex - M or F Birth date _____ Marital Status - M; S; D; W

Physician's Name: _____ Phone #: _____

Psychiatrist's Name: _____ Phone #: _____

Medications: _____

_____

_____

Employment Information

Employment: - F - P/T - Retired - Not Employed - (***circle one)***
Employer_____ Phone _____
Address_____City_____ State____ Zip_____

Insurance Information - Insurance # 1

Insurance Name_____City_____State_____

Telephone #__(____)_____

Subscriber Name_____("Same" if same as patient)

Subscriber Address_____("Same" if same as patient)

Relationship to Patient_____Policy Copay_____

Subscriber ID#_____Group#_____Policy#_____

Who will pay co-payments? _____

Insurance Information - Insurance # 2

Insurance Name_____

Address_____City_____State_____

Telephone #__(____)_____

Subscriber Name_____("Same" if same as patient)

Subscriber Address_____("Same" if same as patient)

Relationship to Patient_____ Policy Copay_____

Subscriber ID#_____Group#_____Policy#_____

Who will pay co-payments? _____

Copayments and Cancellation Policy

Please be aware that copayments are due at the time of service. Center for Family Therapy also has a 24 hour cancellation policy or a charge will be expected of $75.00 for the missed appointment. There is often a waiting list of clients who are in need of an appointment. With enough notice, it is often possible to provide them with an appointment. Insurance companies do not cover the cost of a missed appointment.

Client Signature