

CONFIDENTIAL



I am here to see _____ Date _____

Client Name _____ Home Phone: (____) _____

Address _____ City _____ Zip Code _____

Sex _____ Age _____ Date of Birth ____/____/____ Social Security # _____

Occupation _____ Employer/school _____

Work Phone (____) _____ Cell (____) _____ Marital Status _____

Spouse's Name _____ Social Security # _____

Age _____ Date of Birth ____/____/____ Employer: _____

Occupation _____ Cell (____) _____ Work Phone: _____

IN CASE OF EMERGENCY, CONTACT _____ Phone (____) _____

Children: Name _____ DOB: _____ Living w/you Y ____ N ____

Name _____ DOB: _____ Living w/you Y ____ N ____

Name _____ DOB: _____ Living w/you Y ____ N ____

Parent Information (IF PATIENT IS A MINOR)

Father _____ Home Phone _____

Address _____ City _____ Zip _____

Date of Birth ____/____/____ Social Security # _____

Employer _____ Work Phone _____

Mother _____ Home Phone _____

Address _____ City _____ Zip _____

Date of Birth ____/____/____ Social Security # _____

Employer _____ Work Phone _____

I was referred by _____ Relationship to you: _____

May we send a referral acknowledgment? Yes ____ No ____

If Fee has not been discussed: Total family annual (or monthly) gross income (include all sources): \$ _____ Fee: _____

If you have insurance you intend for us to bill:

We will need a copy of the front and back of the insurance card to bill insurance.

Please make the receptionist or therapist aware you have an insurance card to be copied.

Insurance is billed as a courtesy. It is important that you understand the following:

- I will be charged the full fee for any missed appointment and for cancellations received less than 24 hours prior to my scheduled appointment time. **Insurance will not pay for these and they are my sole responsibility.**
- I am responsible to obtain any preauthorization from my insurance company. If failure to do so results in non-payment from my insurance company, I understand I am financially responsible to pay for these sessions. I am responsible to pay for all deductibles, any and all co-pays, and any balance remaining after insurance has paid their portion and contractual adjustments have been made.
- I understand that the ultimate financial responsibility is mine.
- I have read and understand the above. I authorize payment of authorized benefits be made either to me or on my behalf to Family Consultation Services and its therapists for any services related to outpatient psychotherapy. I further authorize Family Consultation Services to act on my behalf if it is necessary to file a complaint against my insurance carrier.

Signature _____ Date _____

Signature _____ Date _____