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Family Intake Form

Date: Referred by:

Client/ Spouse/ Parent #1: Date of Birth:
Address:

Contact Information (Check which are OK to call/Leave Message):
Home: Cell: Email:

Client/ Spouse/ Parent #2: Date of Birth:
Address: (if different than above):
Contact Information (Check which are OK to call/Leave Message):
Home: Cell: Email:

Client/ Child's Name: Age: Date of Birth: Gender: Grade:

Client/ Child's Name: Age: Date of Birth: Gender: Grade:

Client/ Child's Name: Age: Date of Birth: Gender: Grade:

Person to contact in case of emergency (Tel. & Relationship):

Insurance Information
ASSIGNMENT AUTHORIZATION & RELEASE: I hereby authorize the release of any medical or other information to my insurance company necessary to process this claim. I hereby authorize payment of medical or other benefits to provider of services identified herein. In the event of a claim made to an insurance company seeking reimbursement of charges referred to herein, I agree to assume responsibility for collection of those charges from the insurance company. A copy of this document is as valid as the original.

Signature of policy holder: _____ Date: _____

Insurance Co.: Tel. #:

Mailing Address:

Policy Holder & Policy Holder's date of birth:

Subscriber ID#: Group # / Group Name:

Effective Date of Coverage:

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I hereby authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable upon presentation of a statement of those charges, unless credit arrangements are agreed upon in writing. I agree that all charges shown on those statements shall be deemed to be correct and reasonable, unless I make written protest of the charges within thirty days of the billing date. I agree that the charges will be subject to a late charge of 1.5% per month on the unpaid balance.

Signature of Responsible Person:_____ Date: _____