CENTERS FOR FAMILY CHANGE: APPLICATION FOR SERVICES

CLIENT NAME: ____

Last First MI

Address____

City________________________________State__________Zip____________

Client Home Phone ( ) **Cell Phone ( )** **Work Phone ( )**

Email address: ______________________ **CLIENT BIRTH DATE**: __________

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name______________________________ Social Security No: ______________

Address______________________________City________State______Zip______

Home Phone ( )__________ Work ( )__________ Cell ( )______________

Email:

WILL YOU BE USING INSURANCE Y N **OR PAYING YOURSELF Y N**

WILL YOU BE USING AN EAP Y N EAP INFORMATION________________

Insurance or EAP authorization number (if applicable)______________

PRIMARY INSURANCE INFORMATION

Name of Insurance:______________________ Phone: ( )__________

Address of Insurance________________________ City, State____________ Zip____

Is there a Special Number to call for Mental Health or Substance Abuse? ( )______________

Name of Insured:________________**EMPLOYER**:____________________

Social Security No______________ Group No__________ ID No____________

Relationship to Client: Self____ Spouse____ Parent___ Step-parent___ Other ____________

Address of insured________________________ City ____________Zip______

PLEASE SIGN HERE TO VERIFY THIS IS THE ONLY INSURANCE COVERAGE FOR CLIENT:

Signature________________________**Date**_____________________________

SECONDARY INSURANCE INFORMATION:

**NOTE: We do <u>NOT</u> bill to secondary insurance but we need this information*.

Name of Insurance Carrier ________________________Phone ( )____________

Address of Insurance________________________City____________Zip______

Is there a Special Number to call for Mental Health or Substance Abuse? ( )______________

Name of Insured:____________________**EMPLOYER:**________________________

Social Security No________________ Group No____________ID No______________

I/We authorize the Centers for Family Change to release any information necessary to process this claim.

SIGN____Date:________________

I/We authorize the payment of benefits directly to the Centers for Family Change who accepts assignment. It is understood that the undersigned has the responsibility for payment of services. Assignment of Benefits does not release the undersigned from responsibility of payment.

SIGN____Date:________________

Signature of Insured or Patient

TURN OVER » » » »

Name Age Sex School & Grade or Employer & Occupation

____
____
____
____
____
____

Name of Client's Primary Care Physician:____
Address:________________________________City:____________ Phone:(____)____________

Who referred you to our practice? ______________________ May we thank them? Yes_____ No______

Describe the problems for which the client is seeking treatment____
____

Date Symptoms first appeared ______________Is the client currently taking medication (list type & dosage)
____

Previous Mental Health Treatment: Yes___No___
Date Previous Treatment Began:______________________________

CONSENT AND AGREEMENT TO RENDER SERVICES

I/We hereby consent to treatment at Centers for Family Change for ourselves and/or our children. I/We understand that I/we may choose to terminate treatment at any time, and I/we understand that this agency adheres to the Mental Health and Developmental Disabilities Act. Confidentiality does not apply in instances of child abuse, suicidal or homicidal risks.

Signatures of family members over age 11.	Names of those under age 11.
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

FOR OFFICE USE ONLY

Referral Source:__________________________Affiliation:__________________________

THERAPIST: ___________Location ___________ DIAGNOSIS: DSMV: _________; ___________

ICD10___________;_____________

Fee Arrangement: Indemnity ______ Managed Care _______ other_____________ self pay ______________

Release of info? yes __ no __ Bill Insurance? yes __ no __ Assign Benefit? yes __ no __

The signature below indicates the Therapist is the provider of services and gives permission to CFFC to bill the Insurance Company.

Therapist Signature:____

Date:________________________________