CENTERS FOR FAMILY CHANGE

Date_____ **APPLICATION FOR SERVICES**

CLIENT NAME_____

Last First MI Sex: M F

Address_____

Town_____State_____Zip_____

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

CLIENT BIRTH DATE:_____ Marital Status: S M D Sep

Email address: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name_____ Social Security No:_____

Address_____Town_____Zip_____

Hm Phone ( )_____ Wk Phone ( )_____ Lives with Client?: Y N

Email address: _____

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

WILL YOU BE USING AN EAP Y N EAP INFORMATION_____

PRIMARY INSURANCE INFORMATION

Name of Insurance::_____ 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_____

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 NOT 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.

_____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.

_____Date:_____

Signature of Insured or Patient **TURN OVER » » » »**

Please list all members of your household including the client:

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? Y N
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: Axis I_____ Axis
II_____ Axis III_____ Axis IV_____ Axis
V_____
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.
_____Date:_____
Signature of Therapist