## **CENTERS FOR FAMILY CHANGE** 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? 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 Is there a Special Number to call for Mental Health or Substance Abuse? () Name of Insured:\_\_\_\_\_ Relationship to Client: Self □ Spouse □ Parent □ Step-parent □ Other □ Address of insured PLEASE SIGN HERE TO VERIFY THIS IS THE ONLY INSURANCE COVERAGE FOR CLIENT: Signature SECONDARY INSURANCE INFORMATION: \*NOTE: We do NOT bill to secondary insurance but we need this information. Name of Insurance Carrier\_\_\_\_\_ Phone ( ) Address of \_City\_\_\_\_\_ Insurance Is there a Special Number to call for Mental Health or Substance Abuse? () Name of Insured: 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 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

CONSENT AND AGREEMENT TO RENDER SERVICES  //We hereby consent to treatment at Centers for Family Change for ourselves and/or our children. I/N inderstand that I/we may choose to terminate treatment at any time, and I/we understand that this gency dheres to the Mental Health and Developmental Disabilities Act. Confidentiality does not apply in instances of hild abuse, suicidal or homicidal risks. Signatures of family members over age 11. Names of those under age 11.  FOR OFFICE USE ONLY Referral Source:					
Address:					
Previous Mental Health Treatment: Yes No Date Previous Treatment legan:  CONSENT AND AGREEMENT TO RENDER SERVICES  We hereby consent to treatment at Centers for Family Change for ourselves and/or our children. I/V understand that I/we may choose to terminate treatment at any time, and I/we understand that this gency dheres to the Mental Health and Developmental Disabilities Act. Confidentiality does not apply in nstances of hild abuse, suicidal or homicidal risks. lignatures of family members over age 11. Names of those under age 11.  FOR OFFICE USE ONLY Referral Source:	Name of Client's Prima	ry Care Physician	1:		
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Gee 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 sill the Insurance Company.  Date:	Referral Source:	NLYLocationAx	Affiliation: DIAGNOSIS: Axis I is IV A	xis	
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Date:	oill the Insurance Comp	•	D	lata.	
	Signature of Therapist		D	ate:	