CENTERS FOR FAMILY CHANGE

APPLICATION FOR SERVICES

Date: ________________

CLIENT NAME: ____
Last First M.I.

ADDRESS: ____

CITY:____________________________STATE:________ZIP:_________

Client home phone:_____________ Cell:______________ Work:__________
Email address: ____

CLIENT DATE OF BIRTH:_________________________

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name: ______________________________ Social Security No.:_________________
Address: _________________________________City:_________State: ___Zip:_______
Home Phone:_____________Cell:_______________Work:_______________________
Email:____

WILL YOU BE: Using your insurance: Y N Or paying yourself: Y N

Will you be using your EAP benefits: Y N (if yes please provide)
Name of EAP:___________________ Phone for EAP _______________

PRIMARY INSURANCE INFORMATION

Name of insurance: ___________________________ Phone:_________________
Address of insurance:____
City:____________________ State:__________ Zip:__________

Is there a special number to call for Mental Health Benefits? Phone:_______________

Name of Insured: _____________________ Employer: _______________________
Social Security No: ____________Group No:___________ ID No:______________

Relationship to Client: Self:___ Spouse:___ Parent:___ Stepparent:____ Other: _________
Address of insured: ___________________________City:_________State:_____ Zip:___

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

Signature:_________________________________ Date: _________________________

SECONDARY INSURANCE INFORMATION

*Note: We do **NOT** bill secondary insurance but we need this information.*

Name of insurance: ______________________________ Phone:_________________
Address of insurance: ____
City:_____________________ State:__________ Zip:__________

Is there a special number to call for Mental Health Benefits? Phone:________________

Name of Insured: ______________________ Employer: _______________________
Social Security No: _____________Group No:____________ ID No:______________

Relationship to Client: Self:___ Spouse:___ Parent:___ Stepparent:____ Other: _________
Address of insured:_____________________________City:_________State:_____ Zip:___

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

Signature:___________________________________ Date: __________________________

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

Signature:___________________________________ Date: __________________________

Background Information

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: ___________ State:_____ Zip:_____
Phone: _________________________________

Background Information cont.

Who referred you to our practice?____
May we thank them? Yes ___ No ___

Describe the problems for which you are seeking treatment:______________________
____
Date Symptoms first appeared: ____
Current medications: ____

Previous Mental Health Treatment: Yes___ No ___
Date Previous Treatment Began: ____

CONSENT AND AGREEMENT TO RECEIVE SERVICES

I/We hereby consent to receive treatment at Centers for Family Change, for myself/ ourselves/ our child/children. I/We understand that I/we may choose to terminate treatment at any time. I/We understand that this practice adheres to the Mental Health and Developmental Disabilities Act. Moreover, I/we understand that confidentiality does not apply in instances of suspicion of child abuse, elder abuse, and suicide or homicide risk.

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: Insurance:*_____ *EAP*____ *Self pay*_____ *Other: (specify)*_________

*Release of info: Y*___ *N*___ *Bill insurance/EAP: Y*___ *N*___ *Assign Benefit: Y*___*N*___
The signature below indicates that the therapist is the provider of services and that CFFC is to bill the insurance company or EAP:

*Therapist Signature:*_________________________________
*Date:*__________________