ASSOCIATES IN FAMILY CARE

CLIENT INFORMATION

Today's Date: _____ /_____ /_____

CLIENT INFORMATION: ***Please Print***

Legal First Name:_____ MI:_____ Last Name:_____

Preferred Name:_____ Birthday: _____ /_____ /_____ Birth Sex: ☐Male ☐Female

Address:_____ City:_____ State:_____ Zip Code:_____

Mobile Phone: **(** **)** _____ -_____ May we leave messages? ☐Yes ☐No

Home/Work Phone: **(** **)** _____ -_____ May we leave messages? ☐Yes ☐No

Email Address: _____ Email Appt Reminders? ☐Yes ☐No

Employer/School & Grade:_____

Please fill out <u>ONLY 1</u>: Insurance information or EAP information.

PLEASE NOTE: We **<u>do not</u>** bill secondary insurance. If you submit on your own, you must use the Explanation of Benefits statement sent by the primary ins. company to your address.

Insurance Provider:_____ **ID#:**_____ **Group#:**_____

Client's SSN:_____-_____-_____ (If client is minor) **Guarantor's SSN:**_____-_____-_____

EAP Provider:_____ **EAP Auth. #:**_____ **# of sessions approved:**___

IN THE EVENT OF AN EMERGENCY, AFC may contact:_____

Relationship to Client:_____ **Phone Number: (** **)** _____ -_____

RESPONSIBLE PARTY (Guarantor) PERSONAL INFORMATION: ***only if different than client***

Legal First Name:_____ MI:_____ Last Name:_____

Relationship to Client:_____ Date of Birth: _____ /_____ /_____ ☐**Address Same As Above**

Address:_____ City:_____ State:_____ Zip Code:_____

☐**Same As Above** Mobile Phone: **(** **)** _____ -_____ Leave messages? ☐Yes ☐No

☐**Same As Above** Home/Work Phone: **(** **)** _____ -_____ Leave messages? ☐Yes ☐No

☐**Same As Above** Email Address: _____ Appt Reminders? ☐Yes ☐No

I authorize the release of any information necessary to process claims with my insurance company. I authorize my insurance company to make payments for my treatment directly to Associates in Family Care. I understand that I am responsible for paying my deductible/co-pay (where applicable). I understand a third party is used for this purpose. I authorize the release of information to the third-party biller "Practice Management Solutions Consultants" for the purposes of billing.

Client/Parent/Guardian Signature:_____ Date: _____ /_____ /_____