Client Chart #: _____

Third Party Payer Information

Person receiving services:

First name: _____ Last name: _____ MI: ____

Social Security # _____

Address: _____ Zip Code: _____

Phone #: (Home) _____ (Cell) _____

Birthdate: _____ Age: _____ Gender: ____ F _____ M

Spouse or Legal Guardian:

First name: _____ Last name: _____ MI: ____

Address: _____

Phone #: (Home) _____ (Cell) _____

Personal Responsible for Payment:

First name: _____ Last name: _____ MI: ___

Social Security # _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____ Address: _____

Name of psychiatrist (if applicable): _____

Phone: _____ Address: _____

Name of physician: _____

Phone: _____ Address: _____

Primary Insurance Information:

Name: _____

Phone: _____

Contract/ID#: _____

Group/Acct#: _____

Subscriber: _____

Subscriber DOB: _____

Client relationship to subscriber:

_____

Secondary Insurance Information:

Name: _____

Phone: _____

Contract/ID#: _____

Group/Acct#: _____

Subscriber: _____

Subscriber DOB: _____

Client relationship to subscriber:

_____