Faith Counseling Center

CLIENT NAME:_____
First Middle Last

ADDRESS:_____
Street Apt.# City/State Zip

HOME PHONE #:_____ **WORK #:**_____ **CELL #:**_____

CLIENT SOC. SEC. #:_____

REFERRING SOURCE:_____

FAMILY PHYSICIAN NAME & #:_____

SPOUSE'S NAME:_____ **PHONE #**_____

***PRIMARY MENTAL HEALTH INSURANCE:**_____

Insurance Mailing Address:_____

ID#: _____ Group #: _____ D.O.B.: _____

Yearly Family Deductible:_____ **Yearly Individual Deductible:**_____

Insurance Holder Name:_____

Insurance Holder Social Security Number:_____

Insured Employer Name:_____

***SECONDARY MENTAL HEALTH INSURANCE:**_____

Insurance Mailing Address:_____

ID#:_____ **Group #:**_____ **D.O.B.:**_____

Insurance Holder Name:_____

I hereby agree to pay for services rendered when charges are incurred. I authorize release of any information required to submit my insurance claim and permit a photographic or other facsimile of this authorization to be used in place of the original assignment. I hereby assign Faith Counseling Center, Inc., the mental health benefit I am entitled for services from my insurance company.

Signature of Legally Responsible Party_____

Date:_____ ***We require copies of your insurance cards.**