FAMILY COUNSELING CENTER 1112 WASHINGTON STREET, RED BLUFF 1347 GRANT STREET, RED BLUFF 756 SOLANO STREET, CORNING 530-527-6702

CLIENT INFORMATION SHEET

| Address: Social Security #: Marital Status: Single Married Divorced Separated Other (Please Circle) Employer: Employer Address: Relationship: Address: City/State/Zip: Occupation: Work Ph #: SPOUSE/PARENT INFORMATION SPOUSE: (If Applicable) Social Security #: (OR PARENT FOR MINOR) Address: City/State/Zip: Date of Birth: Employer: Work Ph#: SPOUSE (If Applicable) Social Security #: (OR PARENT FOR MINOR) Address: City/State/Zip: Date of Birth: Employer: Work Ph#: Employer: Work Ph#: Date of Birth: Employer: Work Ph#: Employer Address: Tinsurance Co. Policy #: Group # Group # Address: Telephone #: Secondary - Name of Insured: Self Spouse Child Other (Please Circle) Primary Insurance Co. Policy #: Group # Group | ClientName: | Phone: | | | | | | | |
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| Marital Status: Single Married Divorced Separated Other (Please Circle) Employer: Employer Address: Person Responsible for Bill Relationship: Address: City/State/Zip: Employer: Occupation: Address: Work Ph #: SPOUSE/PARENT INFORMATION SPOUSE: (If Applicable) Social Security #: (OR PARENT FOR MINOR) Address: City/State/Zip: Home Ph#: Date of Birth: Employer: Work Ph#: Employer Address: INSURANCE INFORMATION Primary - Name of Insured: Relationship to Insured: Self Spouse Child Other (Please Circle) Primary Insurance Co. Policy #: Group # Address: Telephone #: Secondary - Name of Insured Relationship to Insured: Self Spouse Child Other (Please Circle) Primary Insurance Co: Policy #: Group # Address: Telephone #: Secondary - Name of Insured Relationship to Insured: Self Spouse Child Other (Please Circle) Secondary Insurance Co: Policy #: Group#: ASSIGNMENT & RELEASE I, the undersigned, certify that all above information is correct to the best of my knowledge. I assign all insurance benefits, if any, otherwise payable to me, to FAMILY SERVICE AGENCY OF TEHAMA COUNTY DBA FAMILY COUNSELING CENTER, for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage. I understand that my signature authorizes the | Birthday: | Social Security #: | | | | | | | |
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| accounts are due and payable at the time service is rendered. It is further understood that if prior notice is not given for cancellation of any appointment, I may be charged for time reserved. I understand that I am responsible for any no-show charges and my insurance will not be billed. No statements will go out to you unless you have a payment due. If you want a statement, please let us know and we will get one out to | insurance benefits, COUNTY DBA FA responsible for all release of any infor accounts are due at not given for cancam responsible fo you unless you have you. | if any, otherwall and country any no-should payable at country and count | vise payable to NSELING CE dless of insurar r records nece the time service ay appointment w charges and | o me, to FAMIL' ENTER, for servence coverage. I ssary to my insuce is rendered. I nt, I may be chad d my insurance ant a statement, p | Y SERVICE AGE ices rendered. I u understand that n rance company. It is further under arged for time rewill not be billed blease let us known. | ENCY OF T nderstand the signature It is understood that served. I ul. No statem | EHAMA nat I am financially authorizes the bood that all if prior notice is nderstand that I ments will go out to | | |
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