SIOUXLAND CHILD & ADOLESCENT THERAPY SERVICES, LLC
CLIENT INFORMATION FORM

Appointment Date:_____
Therapist:_____

Client Information: Please Print Clearly

Name:_____ Birthdate:_____ Age:_____
First MI Last

Physical Address:_____
Street Address City State Zip Code

Mailing Address:_____
❒ Same as Physical /Street Address City State Zip Code

Home Phone: _____Cellular Phone: _____

Email:_____I consent to receive emails at this email: ❒yes ❒no

❒School/Employer:_____
School / Employer Name School / Work Phone

❒Spouse / Partner or ❒ Legal Guardian (if client is a minor)

Name:_____ SS#:_____Birthdate:_____
First MI Last

Address:_____
Street City State Zip Code

Relationship to Client:_____Home Phone:_____Cellular Phone:_____

Email:_____I consent to receive emails at this email: ❒yes ❒no

Employer:_____
Employer Name Work Phone

Family Members / Others Living In Household:

Name	Relationship to Client	Age	Birthdate	School/Employer

Medical Information

Primary Physician:_____
Current Medications:_____
Presenting Concern (Optional):_____
_____

Referral Source:

Name of Referral Source:_____

❒ Attorney ❒Internet Browser / Website
❒ Friend / Relative ❒ Mental Health Professional
❒ Physician ❒Court

Primary Insurance: In order to process your insurance, we must receive *complete* insurance information

Name of Insurance Company:_____

Subscriber Name:_____ Relationship to Client:_____

Insurance Address:_____
Street Address City State Zip Code

Identification #:_____ Group #:_____ Phone #:_____

Have you received pre-authorization if required? ❒ yes ❒ no ❒ not applicable

Pre-authorization will be your responsibility. Siouxland Child & Adolescent Therapy Services, LLC will provide necessary treatment information when requested by the insurance company.

Third Party Responsibility:

Please complete the following information if your account is to be billed to a third party. Please understand that we will not bill a third party unless they have provided us with written verification or a signed financial policy. Any services not reimbursed by a third party will be your responsibility.

Name of Individual and/or Agency:_____

Address:_____
Street Address City State Zip Code

Phone:_____ Has Written Authorization been provided? ❒ yes ❒ no

Assignment and Release

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes Siouxland Child & Adolescent Therapy Services, LLC to submit claims for services rendered. I further authorize insurance companies and other third party payers to make payment directly to Siouxland Child & Adolescent Therapy Services, LLC.

_____
Client or Legal Guardian Signature Date