

Client Face Sheet

Patient Information

1. Patient Name: _____
(Last) (First) (Middle Initial) (Nickname)

2. Address: _____
(City) (State) (Zip)

3. Home Phone: () _____ 4. Work Phone: () _____ Ext #: _____

5. Soc. Sec. #: _____ 6. Birthdate: _____ Age: _____ 7. Sex: M F 8. Marital Status: S M D W

9. Employer: _____ Phone# () _____ Occupation: _____

10. Student/School: _____ Full Time _____ Part Time _____

11. If dependent child, are custodial parents: Married _____ Separated _____ Divorced _____ Other _____

12. Religion: _____ 13. Referred By: _____

14. IN CASE OF AN EMERGENCY NOTIFY: _____ Relationship _____ Phone #() _____

8. Spouse Name: _____ 9. Spouse Work Phone: () _____

Financially Responsible Party (Guarantor) Information

If same as patient, only complete items 5, 6, 7, & 8

1. Guarantor Name: _____ Birthdate: _____
(Last) (First) (Middle Init)

2. Guarantor Address: _____

3. Guarantor Relationship to Patient (circle One): Spouse Mother Father Sibling Other Relative Friend Other

4. Home Phone: () _____ 5. Soc. Sec. #: _____ 6. Drivers Lic. #: _____

7. Guarantor's Employer: _____ Work Phone () _____ Occupation: _____

8. Spouse Name: _____ 9. Spouse Work Phone: () _____

******* Do You Have Insurance? Yes No (If yes, Please complete the Following)*******

1. Primary Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____

2. Subscriber's Name: _____ 3. Relationship to Pt. Self Spouse Parent Other

4. Birthdate: _____ 5. Group ID #: _____ 6. Soc. Sec. #: _____

7. Secondary Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____

8. Subscriber's Name: _____ 9. Relation to Pt: Self Spouse Parent Other

Employer: _____ Work Ph: () _____ Occupation: _____

10. Birthdate: _____ 11. Group ID #: _____ 12. Soc. Sec. #: _____

13. ANY OTHER INSURANCE? _____
 ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Jennifer Cecil, ME, CPC the amount due for services rendered to me or my dependent.

RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: _____ DATE: _____
INSURED PARENT/GUARDIAN

GUARANTOR AGREEMENT: I AGREE TO TAKE FULL RESPONSIBILITY FOR THE ENTIRE AMOUNT DUE FOR ANY AND ALL SERVICES RENDERED BY Jennifer Cecil, ME, CPC. If provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

Guarantor Signature (Patient signature, if patient is guarantor) _____
Date

PATIENT RELEASE OF INFORMATION TO GUARANTOR/ THIRD PARTY AGENCY: I authorize Jennifer Cecil, ME, CPC to release my financial information to my guarantor or third party collection agency (in case that further collection assistance is required). I do _____ Do not _____ want a copy of this release.