ACHIEVE CENTER

Client_________________________________ DOB____________ Gender ☐ male ☐ female
(first) (MI) (last)

Mailing address____________________________ City______________State_______ Zip ________

Marital Status S M D W Employer____

Telephone Home___________________ Work__________________ Cell___________________

May we contact you at home? ☐ yes ☐ no At work? ☐ yes ☐ no On your cell? ☐ yes ☐ no

Person financially responsible________________________ Social Security Number_______________
Relationship to client____________________________________ Home phone_________________
Address__________________________________ City______________State_______ Zip_________
Employer____ Business phone_______________
Referral source____
Emergency contact____ Phone_________________
Family physician/clinic____

INSURANCE INFORMATION

Primary insurance name____
Policyholder name________________________________ Policyholder DOB___________________
Policy number________________________ Group #__________ Insurance Phone #_____________
***Social Security Number of client**____
Secondary insurance name____
Policyholder name________________________________ Policyholder DOB___________________
Policy number________________________ Group #__________ Insurance Phone #_____________

AUTHORIZATION FOR THE PAYMENT OF BENEFITS

I hereby authorize payment directly to ACHIEVE Center, if otherwise payable to me, for counseling services rendered at this clinic. I understand and accept all financial responsibility for the deductible amount and for any outstanding amount after payment of such benefits.

I hereby authorize ACHIEVE Center to release the following information necessary to process my medical insurance claims and the claims of my family members covered by my medical insurance company: *name, date of birth, diagnosis, name of the insurance company, subscriber's name, effective date of policy number, group number, and dates and times services are provided.*

I understand that this authorization is revocable by me at any time but that my revocation of this authorization will result in my personally assuming financial responsibility for services rendered on my behalf that otherwise would have been reimbursed by my insurance company. I understand that a photocopy of this assignment shall be considered as valid as the original.

_______________________________________ _______________________________
Signature of client or parent/guardian Date

As of January 1, 2010 your social security number is required by insurance providers.