ACHIEVE CENTER (Child)

Client_____ DOB_____ Gender ☐ male ☐ female
(first) (MI) (last)

Mailing address_____ City_____State_____ Zip _____

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_____
Parent (mother)_____ DOB_____
Mother's Social Security Number_____
Parent (father)_____ DOB_____
Father's Social Security Number_____
Who is legally responsible for child?_____
With whom does the child reside?_____
Referral source_____
Emergency contact_____ Phone_____
Family physician/clinic_____

INSURANCE INFORMATION

Primary insurance name_____
Policyholder name_____ Policyholder DOB_____
Policy number_____ Group #_____ Insurance Phone #_____
***Child's Social Security Number**_____
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.