

Provider: _____

Interface Center

NEW CLIENT FORM

Client Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____ Cell: _____

Messages can be left at: Home _____ Work _____ Cell _____

Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Sex _____

Primary Care Physician: _____

Permission to Contact Primary Care Physician: Yes ___ No ___ Phone _____

Employment Status: Employed ___ Full-Time Student ___

Employer/School Name: _____

In Case of Emergency _____ Phone: _____

Information of Policy Holder

Client Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

(If Client relationship to insured is "Self" then skip this section)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: _____

Phone: _____ Date of Birth: _____ Social Security Number: _____

Employer: _____

Insurance Authorization and Assignment:

I hereby authorize Interface Center to furnish information requested by my insurance carrier for the purpose of processing claims.

Date: _____ Signature: _____

PLEASE GIVE COPY OF INSURANCE CARD(S) TO THERAPIST OR OFFICE

Primary Insurance Company Information

Insurance Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Plan Name: _____

Group Number: _____

Employer Name/Address: _____

Secondary Insured's information if different

Client relationship to Insured: Self___ Spouse___ Child___ Other___

(If Client Relationship to Insured is "Self" then skip this section)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: _____ Employer Name/Address: _____

Secondary Insurance Company Information

Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Plan Name: _____

Group Number: _____ Employer or School Name: _____