CENTER FOR HUMAN DEVELOPMENT

# Cover Sheet

## CLIENT

**Name** _____
Last First M.I.

**Address** _____

_____
City State ZIP

**Social Security #** _____ **Sex** _____

**Birth Date** _____ **Education Level** _____

**Marital Status** ____ **Date of Marriage** _____
0 – Single, never married 1 – Married 2 – Divorced
3 – Separated 4 – Remarried 5 – Widow/Widower

**Home Phone** _____
May we call home? Y / N Leave message? Y / N

**Cell Phone** _____
May we call cell? Y / N Leave message? Y / N

**Work Phone** _____
May we call work? Y / N Leave message? Y / N

**Employer** _____

*Occasionally, we offer programs or information that we feel may benefit our clients. If you would like to receive these notifications, please provide your email address below.*

**Email** _____

**Physician** _____

**Religious Preference** _____

## FAMILY INFORMATION

| Children/Siblings (if minor) | Birth date | Sex |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## SPOUSE / PARENT *(circle one)*

**Name** _____
Last First M.I.

**Address** _____

_____
City State ZIP

**Social Security #** _____ **Sex** _____

**Birth Date** _____ **Education Level** _____

**Marital Status** ____ **Date of Marriage** _____
0 – Single, never married 1 – Married 2 – Divorced
3 – Separated 4 – Remarried 5 – Widow/Widower

**Home Phone** _____
May we call home? Y / N Leave message? Y / N

**Cell Phone** _____
May we call cell? Y / N Leave message? Y / N

**Work Phone** _____
May we call work? Y / N Leave message? Y / N

**Employer** _____

## INSURANCE INFORMATION

*(Subscriber information must be complete if different from above)*

**Insurance Co.** _____

**Insurance Co. Phone** _____

**Policy/ID #** _____

**Group/Acct #** _____

**Subscriber Name** _____

**Subscriber Address** _____

_____

**Subscriber Phone** _____

**Subscriber Employer** _____

**Subscriber Birth Date** _____

**Subscriber S.S. #** _____

I hereby authorize the Center for Human Development to furnish information to insurance carriers concerning my diagnosis and treatments, and I hereby assign to the above mentioned all payments for services rendered to myself or my dependents. Billing is for a standard 50-minute session; longer sessions will be billed at a higher rate. I understand that I am responsible for any amount not covered by insurance due to deductible, co-pays and non-covered services, and/or incorrect or missing information provided by me. I will be charged a carrying charge of 1½ % per month against my account more than 90 days past due. A photocopy of this authorization and assignment shall be considered as valid as the original.

**Signature** _____ **Date** _____

***(Must be 18 years old or older – failure to sign does not relieve you of your financial obligation.)***