CLIENT ______________________________
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS ____________ CITY ________ STATE ____ ZIP CODE ______

HOME PHONE ________ CELL # ________ SOCIAL SECURITY NUMBER ____________

EMAIL ADDRESS______________________________

AGE ____________ DATE OF BIRTH ____________ MARITAL STATUS ____________

MALE ______ FEMALE ______ TRANSGENDER ______

EMPLOYER ____________________ WORK PHONE ____________

EMERGENCY CONTACT ______________________________
(NAME) (RELATIONSHIP) (PHONE)

REFERRED BY ______________________________

IF CLIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

NAME OF CUSTODIAL PARENT(S) ______________________________

PARENT 1 WORK PHONE ____________ PARENT 2 WORK PHONE ____________

ADDRESS ____________ PHONE ________ H W CELL # ________

CITY ____________ STATE ________ ZIP ______

MEDICAL INSURANCE INFORMATION

IF YOU WANT YOUR INSURANCE FILED, YOU MUST SUPPLY US WITH A COPY OF YOUR INSURANCE CARD

FILE INSURANCE? ❑ YES ❑ NO

INSURANCE COMPANY ______________________________
(NAME) (ADDRESS)

POLICY # ________ GROUP # ________ SOCIAL SECURITY NUMBER ____________

INSURED'S NAME ____________________ DATE OF BIRTH ____________

ADDITIONAL POLICY (IF APPLICABLE) ______________________________

POLICY # ________ GROUP # ________ SOCIAL SECURITY NUMBER ____________

INSURED'S NAME ____________________ DATE OF BIRTH ____________

I HEREBY AUTHORIZE Jewish Family Service to furnish to the above insurance company(s) all information , which said insurance company(s) may request to secure the payment of benefits. I hereby assign all money to which I am entitled for mental health expenses relative to the services rendered by Jewish Family Service, but not to exceed my indebtedness to Jewish Family Service. **I understand I am financially responsible to Jewish Family Service for charges whether or not paid by insurance**. I authorize the use of this signature on all my insurance submissions.

I hereby give consent for treatment to be provided for ______________________________

______________________________ ____________
INSURED OR GUARDIAN SIGNATURE DATE