



CLIENT INFORMATION FORM

***** Please Print *****

First Appointment: _____ Today's Date: _____

CLIENT INFORMATION:

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

Ok to leave message at: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____

Student: _____

In the event of an emergency CornerStone may contact: _____

Relationship: _____ at phone number () _____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):

(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

Ok to leave message at: _____

PRIMARY INSURANCE INFORMATION:

(You must complete this section and present a copy of your insurance card for insurance to be billed)

Insurance Company: _____

Phone Number: () _____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____

Employer: _____

I.D. #: _____

Group #: _____

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to _____, the d.b.a. LLC for this CornerStone Family Services counselor. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ Date _____

I authorize _____, the d.b.a. LLC for this CornerStone Family Services counselor, to release information to _____ for the purposes of billing.

Signature _____ Date _____

PLEASE NOTE: We do not bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

This section must be completed by the Counselor/Coach/CT BEFORE paperwork is processed

Counselor/Coach/CT: _____ **Location:** _____

Estimated amount due at time of service: \$ _____

Scholarship deduction (non-insurance only): \$ _____

Diagnosis 1: _____ **Diagnosis 2:** _____

Miscellaneous Information: _____
