St. Louis CENTER FOR Family Development LLC

Client ID# _____

Client Demographics and Insurance Information

CLIENT DEMOGRAPHICS						
Name			**Date of Birth**		**SSN**	
Home Address						
City		**State**		**Zip Code**		
Home Phone			**Cell Phone**			
Name of Spouse/partner			**Marital Status**			
Grantor-Person responsible for payment (If different from Client)						
Home Address (If different from Client)						
City		**State**		**Zip Code**		
Home Phone			**Cell Phone**			
If Client is a minor, please list the legal guardian's name				**Relationship to Client**		

INSURANCE INFORMATION			
Primary Insurance		**Secondary Insurance**	
Name of Insured		**Name of Insured**	
DOB		**DOB**	
Employer		**Employer**	
Insurance Company		**Insurance Company**	
Member ID #		**Member ID #**	
Group ID #		**Group ID #**	
Copayment		**Copayment**	

DO YOU HAVE MEDCAID/MEDICARE?			
Medicaid #:		**Medicare #:**	

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize my insurance or funding source benefits to be paid directly to St. Louis Center for Family Development, LLC. I understand that I am responsible for all charges not paid which includes missed, late, or cancelled appointments, and co-payments. I understand that all payments are due at the time services are rendered.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize St. Louis Center for Family Development, LLC to release any and all information acquired in the course of treatment necessary to process insurance and funding source claims and secure authorization for treatment.

SIGNATURES

I agree to the above Authorization to Pay Benefits to Provider and the Authorization to Release Information.

_____ _____

Signature of Client, or Legal Guardian **Date**

For Internal Use Only:

Dx:

Dx:

PROTECTED HEALTH INFORMATION