St. Louis CENTER FOR Family Development LLC

Client Demographics and Insurance Information

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

INSURANCE INFORMATION			
Primary Insurance			
Name of Insured		**Deductible**	$
DOB		**Copay**	$
Employer		**CoInsur/OutPocket**	$
Insurance Company			
Member ID #			
Group ID #			
Insur Claims Phone #			

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.

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

For Internal Use Only:

Updated in system – Date:

PROTECTED HEALTH INFORMATION