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New/Changed Client Information

PATIENT'S Information:

Last Name: _____ **First Name:** _____ **Middle Init:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone:
Home: _____ **Preferred? (Yes)___ (No)___**
Business: _____ **Preferred? (Yes)___ (No)___**
Cell: _____ **Preferred? (Yes)___ (No)___**
E-Mail address: _____
Date of Birth: _____ **Social Security Number:** _____
Employer or School Name: _____
Marital Status: (Married)____ (Single)____ (Divorced)____ Sex: (Male)____ (Female)____
Referral Source: _____

PRIMARY INSURED OR OTHER FINANCIALLY RESPONSIBLE PARTY (If applicable):

Last Name: _____ **First Name:** _____ **Middle Init:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone:
Home: _____ **Preferred? (Yes)___ (No)___**
Business: _____ **Preferred? (Yes)___ (No)___**
Cell: _____ **Preferred? (Yes)___ (No)___**
E-Mail address: _____
Social Security Number: _____ **Date of Birth:** _____
Employer or School Name: _____
Patient's relationship to responsible party: (Spouse)____ (Child)____ (Other)_____

The information below is to be completed by the THERAPIST:

Primary Therapist: _____ **Intake Date:** _____
Diagnostic Code 1: _____ **(Required only for insured clients)**
Diagnostic Code 2: _____
Bill Rate: _____
Special Instructions:
_____
_____
_____

INSURANCE INFORMATION (If applicable):
_____ **Copy of Insurance Card – Front and Back – To be attached to this form**
_____ **Signed and Dated HCFA to be attached to this form**

{2421 Hollywood Blvd, Suite 1A, Hollywood FL 33020 * (P) 954 881 1129 * (F) 954 923 9190}

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