Therapist: _____

Interface Center
NEW CLIENT FORM

Client Information- please print

Name: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____ **SS#**_____

City: _____ **State**: _____ **Zip**: _____ **Marital Status**: _____

Phone: _____ Cell: _____ **Work Phone: _____**

Leave messages: Home ___Work ___ Cell ___ Email: _____

Primary Care Physician: _____ **Phone**: _____

Permission to Contact Physician: Yes ___ No ___

Employment Status: Employed ____ Student ____ Retired ____ Disabled ____ Unemployed ____

Employer/School Name: _____

In Case of Emergency: _____**Phone**: _____

Primary Insurance- this section MUST BE COMPLETED if patient is NOT the policy holder

***Insurance Carrier: _____ *Policy ID#: _____**

***Policy Holder: _____*Sex: _____*Date of Birth: _____*SS#_____**

***Policy Holder Address**
(if different than client): _____**City**:_____ **State**: _____ **Zip**:_____

Phone: _____ Employer**: _____Relationship to client: _____**

Secondary Insurance

***Insurance Carrier: _____ *Policy ID#: _____**

***Policy Holder: _____ *Sex: _____*Date of Birth: _____ *SS#_____**
(if different from primary)

***Policy Holder Address**
(if different than client): _____ **City**: _____ **State**:_____ **Zip**:_____

Phone**: _____ **Employer**: _____Relationship to Client**: _____

Insurance Authorization and Assignment:
I hereby authorize Interface Center to furnish information requested by my insurance carrier for the purpose of processing claims. Furthermore, I understand I am financially responsible for all balances not covered by my insurance carrier(s).

Date: _____ Signature: _____

COPY OF INSURANCE CARD _____ COPY OF PHOTO ID _____

***required**