Therapist: _____

Interface Center
NEW CLIENT FORM

Client Information- please print_____

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

Address: _____ **SS#**_____

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

If client is a minor what is the marital status of parents: _____

Phone: _____ Cell: _____

Leave messages: Home _____ Cell _____ Email: _____

In Case of Emergency: _____Phone: _____

Primary Insurance- this section MUST BE COMPLETED _____

Insurance Carrier: _____ Policy ID#: _____

Policy Holder: _____Sex: _____Date of Birth: _____SS#_____

Policy Holder Address
(if different than client): _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ Relationship to client: _____

*****DO YOU HAVE A SECONDARY INSURANCE? YES _____ NO_____**
If yes, please give your card to your therapist or the business office.

Financial Responsibility- this section MUST be completed for ALL patients under the age of 18_____

Name: _____ Date of Birth: _____SS#_____

Address: _____
(if different client)

Cell phone #: _____ Home phone #: _____

Relationship to Client: _____

Insurance Authorization and Assignment:
I agree to receive mental health services from Interface Center for myself and/or my child, and understand that I may terminate these services at any time. Furthermore, I authorize Interface Center to furnish any information requested by my insurance carrier for the purpose of processing claims. I also understand, I am financially responsible for all balances not covered by my insurance carrier(s).

Date: _____ Signature: _____

Relationship to client: _____