CORRIDOR CHRISTIAN COUNSELING CENTER

1110 Tall Grass Ave Tiffin, IA 52340 Phone: 319-545-1545 Fax: 319-545-1546

PLEASE PRINT: Date _____

PATIENT'S NAME: Last _____ First _____ MI_____

Address_____ City_____ Zip_____

Home Phone_____ Cell_____ Please circle preferred number.

May we leave message about appointment reminders? Yes ____ No ____

Sex_____ Birth Date_____ SS# _____

How were you referred? _____

Employer_____ Address_____ Phone_____

SPOUSE'S NAME: Last_____ First_____ MI_____

Address_____ City_____ Zip_____

Home Phone_____ Cell_____ SS#_____

Sex_____ Birth Date_____

Date Married _____

Employer_____ Address_____ Phone_____

When the Patient is a Minor, please fill in the Mother's and Father's information.

MOTHER'S NAME:

Last_____First_____MI_____

Address_____ City_____ Zip_____

Home Phone_____ Cell_____ SS#_____ DOB_____

Employer_____ Address_____ Phone_____

FATHER'S NAME: Last_____ First_____ MI_____

Address_____ City_____ Zip_____

Home Phone_____ Cell_____ SS#_____ DOB_____

Employer_____ Address_____ Phone_____

EMERGENCY CONTACT: Name_____Phone_____

Address_____ City_____ Zip_____ Relationship_____

SEND STATEMENT TO: Name_____Address_____

City_____ Zip_____ Phone_____ Relationship_____

RESPONSIBLE PARTY FOR PAYMENT:Name_____Phone_____Relationship_____

Address_____ City_____ Zip_____

INSURANCE COMPANY: _____ Policy ID_____ Group_____

Insured's Name_____ Employer_____ DOB_____

Authorization#_____ # of Sessions_____ From_____to_____

I affirm that the above information is true:

Signed _____ Date_____

1) ACKNOWLEDGMENT AND AUTHORIZATION FORM

I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice Of Privacy Practices and a copy of the Office Policy Statement for Corridor Christian Counseling Center, LLC.

2) AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER

I hereby authorize Corridor Christian Counseling Center to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, progress and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Corridor Christian Counseling Center. I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

3) AUTHORIZATION TO PAY SUPPLIER

I hereby authorize payment of Medical Benefits to Corridor Christian Counseling Center for services rendered.

4) AUTHORIZATION FOR TREATMENT

I give Corridor Christian Counseling Center consent to treat myself or my minor child.

5) AUTHORIZATION FOR COLLECTION

I understand that if I fail to pay, Corridor Christian Counseling Center reserves the right to take legal action (i.e. collection services, small claims court), and that I will be responsible for all costs involved.

Acknowledgement and agreement of above numbers #1, #2, #3, #4, #5

X_____ _____

Client/Insured Signature/Biological Parent (or Legal Guardian) **Date**