A • C • F
ADULT CHILD FAMILY
COUNSELING OF MASON
6400 Thornberry Ct, Suite 620 • Mason, OH 45040
Ph: 513-229-8386 • Fx: 513-229-8385

Patient Information

Client Name (First, MI, Last)		**Today's Date**
Address		**City, State, Zip**
Date of Birth (MM/DD/YYYY)		**SSN#**
Home #	**Work #**	**Cell #**
Employer/School		**Marital Status** (Single, Married, Divorced, Widowed)

Responsible Party Information

Name of Person Responsible for this Account (First, MI, Last)		**Email Address**
Address		**City, State, Zip**
Date of Birth (MM/DD/YYYY)	**SSN#**	**Employer**
Home #	**Work #**	**Cell #**

Spouse/Other Parent/Significant Other		**Email Address**
Address		**City, State, Zip**
Date of Birth (MM/DD/YYYY)	**SSN#**	**Employer**
Home #	**Work #**	**Cell #**

Insurance Information

If you have secondary insurance coverage, please provide that information as well.

Subscriber (First, MI, Last)		
Primary Insurance		**Mental Health Carrier**
Date of Birth (MM/DD/YYYY)		**SSN#**
ID #	**Group #**	**Sessions Allowed Per Year**
Yearly Deductible Amount		**Copay/Coinsurance**

I authorize the provider rendering the service to submit claims to my health insurance company for all covered services rendered in this practice and authorize and direct the health insurance company to issue payment directly to the provider. I authorize my provider to furnish complete information to my health insurance company regarding services rendered, and hereby claim the amount of indemnity specified in my contract with my health insurance company.

Client Signature of Patient/Parent	**Date**