Jewish Family Service

Today's Date: ____/____/____

Clinician Name: _____

CLIENT INFORMATION

Name: _____ DOB ____/____/____ Sex: F [ ] M[ ]

Address: _____
Street & Apartment # City Zip Code

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Birthplace: _____

Religion: _____ Place of Worship: _____

Race: Caucasian [ ] African American/Black [ ] American Indian/Aleut [ ] Asian [ ] Hispanic [ ] Other [ ]

Marital Status: Single [ ] Married Couple [ ] Unmarried Couple [ ] Widowed [ ] Separated [ ] Divorced [ ]

Veteran: Veteran [ ] Post-911 Veteran [ ] Not a Veteran [ ] Unknown [ ]

Education: Grade Completed ____ GED [ ] High School [ ] Some College [ ] Bachelors [ ] Masters [ ] PhD [ ]

Field of Study: _____

Occupation: _____ Employer _____

Referral Source/Relation: _____

If here for Occupational or Speech services- Reason for Therapy: _____

SPOUSE/PARENT/FAMILY INFORMATION

Name: _____ Relationship to Client _____

DOB: _____/_____/_____ Home Phone: _____ Cell Phone: _____

Email: _____ Preferred method of contact: _____

If by phone, is it okay to leave a voicemail? (circle one) Yes / No

Marital Status: Married Couple [ ] Unmarried Couple [ ] Single [ ] Widowed [ ] Separated [ ] Divorced [ ]

Race: Caucasian [ ] African American/Black [ ] American Indian/Aleut [ ] Asian [ ] Hispanic [ ] Other [ ]

Religion: _____ Place of Worship: _____

Education: Grade Completed: GED [ ] HS [ ] Some College [ ] Bachelors[ ] Masters [ ] PhD [ ]

Employed [ ] Underemployed [ ] Unemployed [ ] Retired [ ] Disabled [ ]

Occupation: _____ Employer: _____

Number of Dependents/Siblings: _____

Name	School	Grade	DOB
1.			
2.			
3.			

Emergency Contact: _____ Phone: _____

If you have health insurance with coverage for services provided by JFS, the information below will assist us in filing insurance claims on your behalf. This does not guarantee payment by the insurer.

RESPONSIBLE PARTY INFORMATION

Name of Insurance Co.: _____

Member ID# (from card) _____ Policy /Group # _____

Policy Holder's Full Name: _____ Insured's SS# _____ - ____ - _____

Phone # of Insurance Co (Provider Service): _____

Employer: _____

Secondary Insurance Name (if any): _____

Member ID# (from card) _____ Policy / Group # _____

Policy Holder's Full Name: _____ Insured's SS# _____ - ____ - _____

Phone # of Insurance Co (Provider Service): _____

Employer: _____

FEE POLICIES AND GUIDELINES

Please read the "Fee Policies and Guidelines" *sheet in your JFS CLIENT INTRODUCTION TO TREATMENT packet prior to completing this section:*

I have read and understand the fee policies of Jewish Family Service.

I understand that Jewish Family Service will bill my insurance company for the full cost of services on my behalf.
I authorize Jewish Family Service to file and assign insurance benefits on my behalf.

_____ _____

Signature of Client / Guardian Date

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Client's or authorized person's signature: I authorize the release of any medical or other information necessary to process my claims. I also request payment of medical benefits to Jewish Family Service who accepts assignment for my services.

Signed: _____ Date: _____

Jewish Family Service

JEWISH FAMILY SERVICE
INFORMED CONSENT SIGNATURE FORM

I, _____, understand that I will be a client of Jewish Family Service and will remain so until either termination of services or 3 months from the last date of contact.

I have been given copies of the following documents:

- Client Introduction to Treatment
- Fee Policies and Guidelines
- Client's Rights Statement
- Discipline Policy
- Client Complaint Procedure
- Policy of Client Confidentiality
- Interdepartmental Release of Information
- Notice of Privacy Practices

I have read and understand the information contained in this packet and voluntarily agree to participate in services from Jewish Family Service for me and/or my family.

Printed Name of Client: _____

_____ _____/_____/_____

Signature of Client / Guardian Date

COMMUNICATION PREFERENCES:

( ) I would like to receive newsletters and updates regarding JFS programs and events.

I request the following limitations relating to communication directed to me by JFS:

You may leave a detailed message at this number:

- Home _____
- Mobile _____
- Work _____

You may send mail to this address:

_____

Street City State Zip Code

You may email me at this address: _____

_____ _____/_____/_____

Signature of Client / Guardian Date