Today's Date: ____/____/____

CLIENT INFORMATION

Name: ____DOB ___/___/___ SS#_________________ 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 [ ]

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

Field of Study: ____________________

Occupation: ______________________________Employer ____

Referral Source/Relation: ____

SPOUSE/PARENT/FAMILY INFORMATION

Name: ____ Relationship to Client _________________

SS# (or other ID) ____________________________DOB: ____/____/____ Phone: _______________________

Email: ____ Birthplace: ___________________________________

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

Marriage Date: _________________ Divorce Date: _________________ # Of Previous Marriages _________

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. *<u>This does not guarantee payment by the insurer</u>.*

<u>Responsible Party Information</u>

Name: ____

Address: ____
Street & Apartment # City Zip Code

Phone: (H) ___________________________ (W) __________________________ (C) ____________________

SS# _____ - ___ - ______ DOB ____/___/____ Relationship to Client: _________________________________

Household Income (Yearly): _____________ Number in Household __________

Medical Insurance Co.: ____

Policy # ________________________ Group # _______________________ Medicare # ____________________

Policy Holder's Full Name: ________________________________

SS# _____ - ___ - ______ DOB ____/___/____ Relationship to Client: _________________________________

Medicare Supplemental Insurance (if applicable)

Company: __________________________________ Policy # ________________ Group # ________________

Name of Physician: __________________________ Phone _______________________________

*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. As discussed and agreed upon, the cost of providing this service is $100 per hour. I agree that I will be charged a fee of $_________ per hour for counseling or assessment services.

I understand that Jewish Family Service will bill my insurance company for the full cost of services on my behalf. I understand that if my fee plus the insurance's payment to JFS should exceed $100 per session, the difference will be refunded to me.

I authorize Jewish Family Service to file and assign insurance benefits on my behalf.

______________________________________ ______________________________________
Signature of Client / Guardian Date