JEWISH FAMILY & CHILDREN'S SERVICE

(ATTACH COPY OF **BACK & FRONT** OF YOUR INSURANCE CARD)

SECTION A			
Client Name	Date of Birth	Social Security Number	
Parent Name, if client is minor (child)	Date of Birth	Social Security Number	
Home Address	City	State	Zip
Billing Address	City	State	Zip
Name of Primary Insurance Company		ID#	Grp #
Name of Secondary Insurance Company		ID#	Grp #
Total # of People in the Home: Total # of Dependents:	Client Employed □ YES □ NO FMHC Client □ YES □ NO (staff to complete)	______________________ Therapist Name (staff to complete)	
Are you requesting a reduced fee? □ YES □ NO If "Yes," complete Section B. If "No," our funding sources require that we collect income level of our clients. Please fill in your annual gross income, and proceed to Section C: $______________________________.			

Section B - GROSS FAMILY INCOME		
Are you a client of the JF&CS Financial Assistance Program? □ YES □ NO		
Family Member	Employer	Annual income as reported on IRS form 1040
		$
		$
Significant Other:	Employer:	
List child support/alimony received annually		$
If you did not file a Tax Return, please note Annual Gross Income (before taxes)		$
SPECIAL EXPENSES		
Total Medical, Dental, Prescription as noted on IRS form 1040 (out of pocket expenses)		$

MONTHLY EXPENSES	
Child Daycare/Adult Daycare	$
Nursing Home/Home Health	$
Child Support/Alimony Payments	$
Co-Pay Amount (if insurance)(Staff to complete)	$
Fee Amount (Staff to complete)	$

Directions for clients requesting reduced fee:
Please attach copies of

1. Back & front of insurance/Medicare/Medicaid cards
2. IRS 1040 - Tax Return form
3. Paycheck
4. Social Security or other award letter

SECTION C

READ CAREFULLY BEFORE SIGNING

I understand that all payments and co-payments are due at time of service. I understand that if I cancel less than 24 hours before my appointment, I am responsible for the full charge.

I authorize release of any medical or other information necessary to process the claim. I authorize that payment from my insurance company, Medicare, or Medicaid be made on my behalf to Jewish Family & Children's Service for any services furnished to me by that agency. I also request payment of government benefits to the party who accepts assignment.

This consent remains in my file and can be revoked by me at any time upon written request by me to my therapist.

If my particular insurance carrier does random site reviews, I understand that insurance representatives may review the contents of my file.

My signature indicates I have read and understand all of the above.

Client Signature____

Signature of parent if client is minor (child) Date

(Staff to Complete)

Fee Determination Update (Date ______________________)

Have you become eligible for insurance or disability since you became a client? □ YES □
Specify:____

Staff: If "yes", client to sign insurance and/or Medicare signature form.

Has your income or employment status changed since you became a client? □ YES □ NO
Specify:____

Staff: If "yes", ask client to provide pay stub or tax return

Attest: Nothing has changed? □ YES □ NO

FMHC clients: Are you still being seen at the clinic? When was your last visit & how much is your fee? $______________________.

Client Signature **Therapist Signature**

Fee Determination Update (Date ______________________)

Have you become eligible for insurance or disability since you became a client? □ YES □
Specify:____

Staff: If "yes", client to sign insurance and/or Medicare signature form.

Staff: If "yes", askc client to provide pay stub or tax return

Has your income or employment status changed since you became a client? □ YES □ NO
Specify:____

FMHC clients: Are you still being seen at the clinic? When was your last visit & how much is your fee? $______________________.

Attest: Nothing has changed? □ YES □ NO

Client Signature **Therapist Signature**