CORNERSTONE
FAMILY SERVICES

CLIENT INFORMATION FORM

********** Please Print **********

First Appointment: _____ Today's Date: _____

CLIENT INFORMATION:

Last Name: _____ Middle Initial: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____ Ok to Send Email Reminders: Y:_____ N:_____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____ Student: _____

In the event of an emergency CornerStone may contact: _____

Relationship: _____ at phone number ( )_____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):
(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____ Middle Initial: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____ Ok to Send Email Reminders: Y:_____ N:_____

PRIMARY INSURANCE INFORMATION:
(*You must complete this section and present a copy of your insurance card for insurance to be billed*)

Insurance/EAP Company: _____ Phone Number: ( )_____

If Not Using Insurance/EAP:

I Am Electing to Self-Pay or Insurance is Not Applicable: Initial:_____ Date:____/____/_____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____ Employer: _____

I.D. #: _____ Group #: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Please Sign Below.

I authorize _____ to release information to _____ for the purposes of billing.

Signature _____ Date _____

Please Also Sign Below If You Will Be Using Insurance and/or EAP.

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to _____. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ Date _____

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.