Family Service, Inc.

Client Registration Form

Please Type or Print

Date___________

Client Information:

Last Name:	First:		MI:
Street:	City:	State:	Zip:
Social Security #:	Birth Date:	Marital Status	Sex: ☐ M ☐ F
Home Telephone:	Daytime Telephone:	Cell Phone:	

Employer:

Employer Name:

CAN YOU BE CONTACTED AT? HOME __________ WORK _____________ CELL __________

APPT. REMINDERS WILL BE MADE PRIOR TO YOUR APPOINTMENT. HOW WOULD YOU PREFER WE CONTACT YOU:

PHONE:___H___W___C or EMAIL:_______________________________ NO REMINDER CALL: ____

Responsible Party Information: **(if different than client)**

Last Name:	First:		MI:
Street/ RFD:	City:	State:	Zip:
Relation to Client:	Social Security #:	Birth Date:	
Employer Name:	Employer Telephone:		

Household Information: Due to Family Service receiving United Way funds, the following information is gathered on a voluntary basis.

Number of people in household

____

SPOUSE (or parent(s) if client is a minor)	OTHER CHILDREN IN HOUSEHOLD:
Name:___________________________________	Name Age Sex
Address:_________________________________	____
_________________________________	____
	____

GROSS ANNUAL HOUSEHOLD INCOME	ETHNIC GROUP		
_________________________________		Asian	White
		Black	Hispanic
		Native American	Other ___________

Medicaid/Medicare Information:

Is Medicare your primary Insurance?	☐ Yes ☐ No
Medicare #	Effective Date:

Primary Insurance: Please provide your Ins. card to the front desk

Is precertification Required? ☐ Yes ☐ No

Insurance company Name:		Telephone:	
Street/ RFD:	City:	State:	Zip:
ID/ Policy #	Group #		
POLICY HOLDER INFORMATION: Last Name:	First:		MI:
Patient's relation to insured:	Social Security:	Birth Date	Sex: ☐ M ☐ F
Employer Name:	Street:	City:	State & Zip:

Secondary Insurance:

Is precertification Required? ☐ Yes ☐ No

Insurance company Name:		Telephone:	
Street/ RFD:	City:	State:	Zip:
ID/ Policy #	Group #	Effective Date	Expiration Date
POLICY HOLDER INFORMATION: Last Name:	First:		MI:
Patient's relation to insured:	Social Security:	Birth Date	Sex: ☐ M ☐ F
Employer Name:	Street:	City:	State & Zip:

Financial Policy:

1) Payment is due at time of service, unless other arrangements have been made.
2) All insurance claims will be filed by Family Service, Inc. unless otherwise directed.
3) Family Service, Inc. reserves the right to use any and all methods authorized by South Dakota law to collect accounts past due.

Signature: Date:

Assignment of Benefits:

I have read and forgoing policy and understand that I am financially responsible for this bill regardless of insurance coverage. I authorize and request that insurance benefits be paid to Family Service, Inc.

Signature: Date:

Release of Information: (only if using insurance)

In order to process benefits payable, I hereby request and authorize this clinic to release any information regarding my medical history, symptoms, treatment, examination results, diagnosis, prognosis, mental or physical condition. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain effective and valid until this office receives a written revocation signed by me, and shall be both retrospective and prospective without limitations.

Signature: Date: