# MIDWEST FAMILY & COMMUNITY RESOURCES
## APPLICATION FOR SERVICES

**Date_____**

**CLIENT NAME**_____
Last First MI Sex: M F
Address_____

Town_____State_____Zip_____

**Client Home Phone ( ) Cell Phone ( ) Work Phone ( )**

**CLIENT BIRTH DATE_____** Marital Status: S M D Sep

**WHO IS RESPONSIBLE FOR THIS ACCOUNT?**

Name_____Social Security No:_____

Address_____Town_____Zip_____

Hm Phone ( ) Wk Phone ( ) Lives with Client? Y N

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**WILL YOU BE USING INSURANCE Y N OR PAYING YOURSELF Y N**

WILL YOU BE USING AN EAP Y N EAP INFORMATION_____

**PRIMARY INSURANCE INFORMATION**

**Name of Insurance: _____** Phone: ( )_____
Address of Insurance _____City_____ Zip_____
Is there a Special Number to call for Mental Health or Substance Abuse? ( )_____
**Name of Insured: _____ Employer _____**
**Social Security No. _____**Group No _____ID No _____
Relationship to Client: Self Spouse Parent Step-parent Other _____
Address of insured _____City _____ Zip_____

**PLEASE SIGN HERE TO VERIFY THIS IS THE ONLY INSURANCE COVERAGE FOR CLIENT:**

**Signature _____Date _____**

**SECONDARY INSURANCE INFORMATION**
***NOTE: We do NOT bill to secondary insurance but we need this information.***

**Name of Insurance Carrier _____**Phone ( )_____
Address of Insurance _____City _____ Zip _____
Is there a Special Number to call for Mental Health or Substance Abuse? ( )_____
**Name of Insured _____ Employer _____**
**Social Security No. _____** Group No _____ ID No _____

**I/We authorize Midwest Family & Community Resources to release any information necessary to process this claim.**

**SIGN _____DATE _____**
I/We authorize the payment of benefits directly to Midwest Family & Community Resources who accepts assignment. It is understood that the

undersigned has the responsibility for payment of services. Assignment of Benefits does not release the undersigned from responsibility of payment.

**SIGN _____DATE _____**

Signature of Insured or Patient **TURN OVER>>>>>>>**

Please list all members of your household including the client:

| Name | Age | Sex | School & Grade or Employer & Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____

Name of Client's Primary Care Physician: _____

Address: _____City: _____Phone:(_____)_____

**Who referred you to our practice? _____**May we thank them? Yes_____ No_____

Describe the problems for which the client is seeking treatment _____

_____

Date Symptoms first appeared _____ Is the client taking medication? (list type & dosage)

_____

**Previous Mental Health Treatment: Yes_____ NO_____**

**Date Previous Treatment Began:** _____

**CONSENT AND AGREEMENT TO RENDER SERVICES**

I/We hereby consent to treatment at Midwest Family & Community Resources for ourselves and/or our children. I/We understand that I/we may choose to terminate treatment at any time, and I/we understand that this agency adheres to the Mental Health and Developmental Disabilities Act. Confidentiality does not apply in instances of child abuse, suicidal or homicidal risks.

| **Signatures of family members over age 11.** | **Names of those under age 11.** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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**FOR OFFICE USE ONLY**

**Referral Source: _____ Affiliation: _____**

THERAPIST _____ Location _____ DIAGNOSIS: Axis I _____ Axis II _____

Fee Arrangement: indemnity □ managed care □ other _____ self pay _____

Release of info? yes □ no □ Bill Insurance? yes □ no □ Assign Benefit? yes □ no □

The signature below indicates the Therapist is the provider of services and gives permission to MFCR to bill the Insurance Company.

_____ Date: _____

Signature of Therapist