Adult Registration

Center for Africans Now in America

Form 3

Adult Registration/Consent for Treatment				
Date: _____		Diagnosis: _____		
		Male Female Age _____		
		S# _____		
Social Worker:	Phone:	Fax:		Date:
Therapist:				Date:
Client/Patient				
Name-Client:		DOB		
Address:		Home Phone#:		
City:	State:	Zip:	Work Phone#:	
Marital Status: Single Married Separated Widowed Divorced Other				
Occupation:		Employment Status:		
Employer		Job Title:		
Referred by:		Relationship:		
Primary Insurance				
Name-Primary Insurance Company:		Phone ( )		
Address-Ins. Company:	City:	State:	Zip:	
Policy ID #:		Group/Plan #		
Policy Holder Information (If the patient is not the employee/policy holder				
Last Name:	First Name:	Relationship:		
Address:	City:	State:	Zip:	DOB:
Employer:		Soc. Sec#:		
Secondary Insurance				
Name-Primary Insurance Company:		Phone ( )		
Address-Ins. Company:	City:	State:	Zip:	
Policy ID #:		Group/Plan #		
Policy Holder Information (If the patient is not the employee/policy holder				
Last Name:	First Name:	Relationship:		
Address:	City:	State:	Zip:	DOB:
Employer:		Soc. Sec#:		
Responsible Party				
Name:		Relationship:		
Address		Phone: { }		

Agreement and Release

_____, certify that I have insurance coverage as noted above. I have authorized the healthcare provider listed above for any Insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges my insurance did not pay. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail a bill statement to me at my current address. I authorize the use of my signature on any insurance submissions.

_____ _____ _____

Name Relationship Date

_____ _____ _____

Signature Relationship Date