INITIAL INTAKE FINANCIAL INFORMATION

For under 18 years of age
8310 Ewing Halsell Drive
San Antonio, Texas 78229

ecumenical
CENTER FOR RELIGION AND HEALTH
healing & growth through knowledge & faith

Please Complete Both Sides

Client Information

Name: _____
Address: _____
_____
School District: _____
School: _____

Home Phone: _____
Date of Birth: _____ Age: _____
Gender: Male Female Grade: _____
General Reason for Referral:
___ Grieving ____ Moody
___ Home Issues ____ Uncooperative
___ School Issues ____ Other: _____

Ethnicity:
☐ Anglo ☐ Hispanic ☐ African-American ☐ Asian ☐ Decline ☐ Other: _____

Faith:

☐ Assembly of God	☐ Baptist	☐ Christian	☐Disciples of Christ	☐ Episcopal
☐ Jewish	☐ Lutheran	☐ Methodist	☐ Presbyterian	☐ Roman Catholic
☐ United Church of God	☐ Unitarian	☐ Buddhist	☐ Islam	☐ Hindu
☐ Non-Denominational	☐ Confucian	☐ None	☐ Decline	☐ Other: _____

Parent/Guardian Information

Relationship to Client: _____
Name: _____
Address: _____
_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Date of Birth: _____
SSN: _____

Relationship Status: Single Committed Relationship Married Divorced

Please indicate the phone number you want to be contacted at: _____

Primary Insurance Company Information

Ins. Co Name: _____
Phone: _____
ID Number: _____
Policy Number: _____
Group Number: _____
Relationship to Client: _____
SSN of Policy Holder: _____

Employer: _____
Policy Holder: _____
Policy Holder's Address: _____
_____
Policy Holder's Home Phone: _____
Policy Holder's Work Phone: _____
Policy Holder's Date of Birth: _____

Secondary Insurance

Ins. Co Name: _____
Phone: _____
ID Number: _____
Policy Number: _____
Group Number: _____
Relationship to Client: _____
SSN of Policy Holder: _____

Employer: _____
Policy Holder: _____
Policy Holder's Address: _____
_____
Policy Holder's Home Phone:_____
Policy Holder's Work Phone: _____
Policy Holder's Date of Birth: _____

Payment Policy

All services rendered are the financial responsibility of the client or the client's parent or guardian. The client is responsible for the payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers. **Authorization of Payment:** I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

CANCELLATION AND RETURNED CHECK POLICIES

Because counseling hours are reserved, the Ecumenical Center charges for sessions canceled when less than 24 hours notice is given.

There will be a $25 charge for each returned check or "do not honor" credit card payment.

I have read and understand these policies.

Initial_____

ACKNOWLEDGMENT OF REFERRAL

It is the practice of The Ecumenical Center to acknowledge and thank members of the professional community for their trust in referring persons to us. Your signature below gives us permission to make such contact by phone or letter.

Referred by:

☐ Pediatrician ☐ Minister ☐ Psychologist ☐ Psychiatrist ☐School ☐Other

Name of Referring Individual: _____

Street Address: _____ City:_____ Zip:_____

Phone: _____

Initial: _____

Signed: _____ Initial: _____

Print Name: _____

Relationship to Client: _____

Date: _____