Insights Educational and Treatment Services

Main Office
1441 Saint Andrews Road
Columbia, SC 29210-5929
P: 803.750.8444

Satellite Office
285 CedarCrest Drive
Lexington, SC 29072
P: 803.808.1221

New Client Form

Date:_______________________________ **Place of Service: Columbia or Lexington**

Client Name: ____**Date of Birth:** _______________**Gender:**_____M / F

Parent Name: ____

Address: ____

City:______________________________________**ST:**________________**Zip:** ____

Phone:____________________________**Cell:** ______________________**Email:** _________________________________

Social Security #:______________________**Marital Status:** ________________

Emergency Contact:_________________________**Contact Relationship:** ___________________________**Contact Phone:**____ ________________________________

Employer: ____

Insurance	**Primary Insurance**	**Secondary Insurance**
	Policy Holder's Name	**Policy Holder's Name**
	Policy Holder's Address	**Policy Holder's Address**
	Policy Holder's DOB and Social Security #	**Policy Holder's DOB and Social Security #**
	Policy Holder's Phone	**Policy Holder's Phone**
Signature	I hereby authorize assignment of benefits for all medical claims pertaining to Insights Educational and Treatment Services to be made to Insights Educational and Treatment Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release of all medical information necessary to secure the payment from said insurance companies. If this account has to be turned over for collection, the undersigned guarantor agrees to pay attorney fees if necessary and all collection fees, which is an additional charge above your normal charge. There will be a $35.00 charge added to your account on all returned checks. There will be a $35 charge added to your account for any balances that are 90 days past due and not paid in full. I have read and fully understand Insights Educational and Treatment Services Financial Policy given to me. I guarantee that I am of legal age. ____ **Client/Responsible party if client is under 18 or disabled** **Date** **Person Financially Responsible for Balance Not Covered by Insurance:** [ ] Client [ ] Spouse [ ] Client [ ] Guardian	

I acknowledge that if I miss an appointment, or do not give a minimum of 24 hours' notice of cancellation, that I will pay the cost of the session missed.

____ ____
Client or Guarantor **Date**

Reason for Visit: ____

How did you hear about us? ____

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You may be contacted by Cornerstone Medical Billing for additional billing information.