SOLUTIONS OUTPATIENT SERVICES
4300 Mac Arthur Avenue, Suite 270
Dallas, TX 75209
Phone: (214) 369-1155 **www.sosdallas.com** **Fax: (214) 369-1710**

CLIENT INFORMATION FORM

(Please Print)

Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) S M D W Other _____

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr/Psy _____ ❑ Insurance ❑ Website
❑ Family ❑ Friend ❑ Attorney _____ ❑ AA/NA/Al-Anon ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD & DRIVERS LICENSE TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Please Select Your Primary Insurance Provider	❑ Aetna ❑ Cigna ❑ United Behavioral Health ❑ Blue Cross/Blue Shield ❑ Principal ❑ Other _____

What is the authorization phone number?	❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name	Relationship to Client	Home Phone No. ( )	Cell Phone No. ( )
Complete Address			
Email			

SOLUTIONS OUTPATIENT SERVICES

CLIENT INFORMATION FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to Solutions Outpatient Services.

_____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize Solutions Outpatient Services to submit my weekly payments to the following credit card (only Master Card or Visa). I understand that if I wish for Solutions to discontinue this agreement that I will make this request by email, call, or fax. I accept that I am responsible to inform Solutions when any pertinent changes have occurred with my card (i.e., billing address changes, a new card with new numbers or expiration date)

❑ **Master Card** ❑ **Visa** **Credit Card #** _____

Name on Credit Card _____ **Expiration Date** _____

Security Code on Back of Card _____

Billing Address for Card _____

STREET ADDRESS OR PO BOX

_____ _____ _____

CITY STATE ZIP CODE

X _____

CLIENT/GUARDIAN SIGNATURE DATE