Destination Hope
Phone 817.366.3494

Client Information

Date:_____

Client's Name: _____
First Middle Initial Last

Address: _____

City:_____ State: _____Zip: _____

Social Security #: _____ Date of Birth: _____ Email_____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Parent/Guardian Information:

Name:_____
First Middle Initial Last

Address (if different from client): _____

Social Security #_____ Date of Birth_____ Email: _____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Other Information: **Dependents**: _____
Name Relation to client DOB

_____
Name Relation to client DOB

_____
Name Relation to client DOB

Church Affiliation: _____ Referred by: _____

Insurance Information

(Note: Please present insurance card with this form to be photocopied. Thank you.)

Name of Insured: _____**Date of Birth:** _____/_____/_____

ID#: _____ **Group#:** _____ ***DSM:*** _____

Insurance Carrier: _____

Address: _____

CITY:_____**ST:** _____**ZIP:** _____

Benefit/Eligibility Phone Number: (____)_____ **Deductible:**_____

Insured's Employer: _____

Address: _____

City: _____ST: _____ZIP: _____ Phone: _____

I authorize the release of any medical or other information necessary to process this claim.

_____
Insured's or Authorized Person's Signature

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

_____
Insured's or Authorized Person's Signature