# Information Sheet and Service Contact

Client: _____ Date of Birth: _____

Address of Client: _____

City: _____ State: _____ Zip Code: _____

If Client is a minor, Parent/Guardian Name: _____

Address of Parent/Guardian, if different: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (H) _____ (C) _____

Would you like email and text reminders? Yes _____ No _____

Email address: _____ *email required for text opt-in

**By including your email address and cell phone you authorize Platteville Family Resource Center staff to send email and texts regarding appointments. This may include confirmation or reminders of appointments, as well as notification of need to cancel an appointment. In the case of a cancellation, we will also attempt to reach you via telephone. We do not give out email addresses or send promotional materials.**

Place of Employment: _____ Work Phone Number: _____

May we contact your work if needed? _____ Yes _____ No

Social Security Number: _____ Marital Status: ____ Single___ Married___ Sep/Div.____

To whom should bills be sent? _____ Date of Birth of Responsible Party: _____

Billing address if different from yours: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Member ID & Group #: _____

***Please present your insurance card so we may make a copy for our files.***

**Please Read Carefully and Sign**

As a service to me, the center will submit any insurance claims for payment, but *any* remaining balance after my insurance company pays is my responsibility.

I would like the Platteville Family Resource Center, Inc. to file my insurance claims for me. I authorize the release of any medical information necessary to process payment of claims.

X _____ X _____

Client & Date Parent/Guardian & Date