CLARKSTON FAMILY THERAPISTS, LLC
5639 Sashabaw Road
Clarkston, MI 48346

_____ _____

Patient's Name Please print Birth date

_____ _____

Address City, State, Zip Code

_____ _____ _____

Telephone Home/Cell Work Email

I authorize Clarkston Family Therapists, LLC to leave a message regarding billing and/or appointment needs.

Yes ____ No____

If Patient is a Minor:

Name of Parent/Guardian _____

Home Phone _____ Cell _____ Work _____

Primary Insurance:_____ Phone _____

Policy Holder's Name_____ **Birth date**:_____

Policy Holder's Address _____
If different than above

_____

Policy Number Group

_____

Social Security Number

_____ _____

Employer Phone Number

I hereby consent for treatment at Clarkston Family Therapists, LLC. I understand that co-payments are paid at the time of service. A no show fee will be charged for appointments not cancelled 24 hours in advance**. I hereby authorize treatment and the release of patient records to my insurance company(s) for the purpose of authorization of services and payment of the bill.**

_____

Patient's Signature **or** Parent/Legal Guardian of Patient Date

_____

Received Date

DX: _____(Office use only) Therapist _____