Client Name _____ Medicaid #_____

Birthdate _____ Insurance # _____

Client and Payment Information

Client Address _____ City/State/Zip _____

Client SS#: _____ Guardian name /address _____

Phone # _____ Email _____

Foster parent/ address/phone _____

I understand that I am financially responsible for any services received. I agree to pay Transformations any co-pay, deductibles, and co-insurance agreed upon with my insurance company. *I give Transformations permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment.*

PRIMARY INSURANCE: **Provider must obtain a copy of both sides of all insurance cards**

__ Medicare (always primary) ___ Private Insurance (primary over Medicaid) ___ Medicaid

Policyholder (if other than client) _____ Policyholder's Date of Birth _____

Policyholder address (if different from client) _____

Primary Insurance Company Name _____

Policyholder's Employer (if applicable) _____

Policy Number _____ Group # _____

Social Security # of Policyholder (if other than client) _____ Payor ID _____

SECONDARY INSURANCE:

___ Medicaid (secondary to other insurances) ___ Private Insurance (secondary to Medicare)

Policyholder _____ Policyholder's Date of Birth _____

Policyholder address (if different from client) _____

Secondary Insurance Company Name _____

Policyholder's Employer _____

Policy Number _____ Group # _____

Social Security # of Policyholder (if other than client) _____ Payor ID _____

CLIENT PAYMENT RESPONSIBILITIES

Private pay agreement _____

Transformations accepts credit cards, checks, money orders and cash payments. Payment is expected at the time of service and arranged with your service provider.

Client or Guardian Signature _____ Date _____

Witness _____ Date _____