# 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 to opt-in to receive text message? Yes _____ No _____

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

**By opting to receive text messages, you authorize Platteville Family Resource Center staff to send emails and texts regarding appointments. This may include confirmation or reminders of appointments, as well as notification of need to cancel an appointment. In the event of 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 _____

Marital Status: Single____ Married____ Sep/Div._____ Widowed _____

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

Billing address if different from yours: _____City: _____ State: ___ Zip:_____

Insurance name: _____ Member ID: _____ & Group #: _____

Subscriber name:_____ Subscriber DOB: _____

***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