



Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Client Demographics

			Title 19#:
Legal Client Name	Last:	First:	Middle Initial:
Client Address	Street:		
	City:	State:	Zip Code:
Phone	Home: () <input type="checkbox"/> Yes, may leave message	Cell: () <input type="checkbox"/> Yes, may leave message	Work: () <input type="checkbox"/> Yes, may leave message
	Age:	Birthdate:	Birthplace:
Religious/Spiritual Affiliation:		Race/Ethnicity:	
Education	Grade Completed:	Field:	Degree:
	Student at:		
Were you raised by: Both Parents <input type="checkbox"/> Single Parent <input type="checkbox"/> Relative <input type="checkbox"/> Foster Parent <input type="checkbox"/> Institution <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Step Parent <input type="checkbox"/>			
Father's Name:			Age:
Occupation:			
Mother's Name:			Age:
Occupation:			
Brothers & Sisters (including yourself) in birth order:			
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:
Relationship Status	Single	Divorced	Widowed
	Married; Spouse Name:		Years Married:
	Age:	Occupation:	
Children	M F Name:		Age:
	M F Name:		Age:
	M F Name:		Age:
Employment	Student	Unemployed	Disabled
	Employed by		How long?
EMERGENCY CONTACT: _____			Relationship: _____
Home: () <input type="checkbox"/> Yes, may leave message			Cell: () <input type="checkbox"/> Yes, may leave message
			Work: () <input type="checkbox"/> Yes, may leave message



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Consent for Services

Client's Name:	Client's DOB:	Title 19#:
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Billing Authorization – Please check the insurance that applies

	IA Health Link / Iowa Medicaid Member #	
	MCO	MCO #
	I understand and agree to pay the amount of \$_____ at the beginning of each session, which is the fee based on the established sliding fee scale, if applicable	
	I understand my EAP is covering _____ sessions.	
	Client or Guardian employed by:	
	Insurance will be billed. Co-Pay due at the beginning of each session \$	
	Insurance Company:	
	Client or Guardian Employed by:	
	Name of Insured:	DOB of Insured:
	Member Number:	Group Number:

- I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I authorize the insurance carrier to pay the provider directly. I understand that I am responsible for all payments. Any monies received by the clinician from the insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full.
- I understand that Southwest Iowa Families and my health plan representatives may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

PLEASE INITIAL BELOW to confirm that you were notified of & offered a copy of
 _____ Client Rights & Responsibilities
 _____ Grievance Policy included in the Client Rights & Responsibilities.
 _____ Notice of Privacy Practices (HIPAA), including Limits of Confidentiality and Access to Records.
 _____ Description of therapy and its possible risks, benefits, and alternatives
 _____ I agree to pay for services not covered by my health plan & understand what will be shared for billing purposes. Sessions cost \$125.

My signature indicates my Consent for Services based on my opportunity to review the information on this page and acknowledges that a copy of all of these documents were offered to me and can be requested at any time.

Client's Signature	<input type="checkbox"/> Photo ID on file	Printed Name	Date
Legal Guardian's Signature	<input type="checkbox"/> Photo ID on file	Printed Name/Relationship	Date
Is there anyone else who is able to legally sign for this individual?	Yes	No	
Name _____			
Witness			Date