Date _____ **FAMILY INVENTORY** Account # _____

(For office Use Only)

Client Last Name | First | MI | Sex | Date of Birth

Street Address/Apt # | City | State | Zip | ( ) Best Contact Phone

RESPONSIBLE PARTY

(NOTE: Only a client or his/her legal guardian can be the responsible party their written consent of the legal guardian)

Last Name | First | MI | Sex | Date of Birth

Street Address/Apt # | City | State | Zip | ( ) Home Phone | ( ) Cell Phone

Social Security Number | Email Address

Employer | ( ) Work Phone

SPOUSE OR OTHER PARENT/GUARDIAN

Last Name | First | MI | Sex | Date of Birth

Street Address/Apt # | City | State | Zip | ( ) Home Phone

Employer | ( ) Work Phone | ( ) Cell Phone

Relationship to client (e.g., parent, step-parent, foster parent, parent's partner, etc.)

EMERGENCY CONTACT OTHER THAN PARENT OR SPOUSE

Name | Relationship | ( ) Best Contact Phone

PRIMARY INSURANCE COMPANY

Company Name_____
Company Address_____
Policy Holder_____
Policy Number_____
Group Number_____
Effective Date_____

SECONDARY INSURANCE COMPANY

Company Name_____
Company Address_____
Policy Holder_____
Policy Number_____
Group Number_____
Effective Date_____

PLEASE LIST NAMES OF ALL SIBLINGS OR CHILDREN OF CLIENT STARTING WITH THE FIRST BORN

Name	Date of Birth	Sex	Dx (For Office Use Only)

I hereby authorize MidWest Behavioral Health, LLC to release any information obtained in the course of treatment to my insurance provider. This authorization shall remain in effect until I direct revocation of this authorization in writing. I further authorize payments by my insurance provider directly to my psychologist/therapist/psychiatric provider. Pursuant to any applicable provider relations agreement, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature_____ **Date**_____