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

_____ _____
Patient's Name Birth date:

_____
Address City, State, Zip Code

_____ _____ _____
Telephone Home Cell Work

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 apply 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

_____
Witness Date

DX: _____(Office use only)