

Client Information Form

The Renaissance Center
6665 Security Blvd.
Woodlawn, MD 21207

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthday: _____ Social Security Number: _____ - _____ - _____

Sex: _____ male _____ female Marital Status: S M D W

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Emergency Contact Name: _____ Relationship _____ Phone(_____) _____ - _____

Primary Insurance:

Secondary Insurance:

Company: _____

Company: _____

Insured Name: _____

Insured Name: _____

Relationship: _____ DOB: _____

Relationship: _____ DOB: _____

Co-Pay: _____ Effective Date: _____

Co-Pay: _____ Effective Date: _____

Policy No: _____

Policy No: _____

Group No: _____

Group No: _____

Employer: _____

Employer: _____

Guarantor Information: (Parent, Guardian, or Responsible Party)

Name: _____ D.O.B. _____ Relationship: _____

Address: _____ Phone Number:(_____) _____ - _____

City: _____ State: _____ Zip: _____

AUTHORIZATION:

I authorize The Renaissance Center to apply for benefits on my behalf for services rendered by the facility. I request payment from my insurance company be made directly to The Renaissance Center and its Associates. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the responsibility and obligation to pay for medical services provided, when a statement is rendered. I agree that all bills are due when rendered and I agree I will be charged a fee for missed appointments without 24 hour notice. I agree that all such amounts are reasonable. I further agree in the event that my account shall be referred to an attorney for collection, that I agree to pay and be responsible for the amount of such bill together with any and all collection costs, private process servers fees, attorneys fees of one-third of the amount of such bill at the time of referral at time of collection, which sum I further agree is reasonable plus court costs.

Signature of Client or Guardian: _____ Date: ____/____/____

