UNITY FCI THERAPY SERVICES LLC

Client Application for Services

Client Number_____ **Date:** _____ **Counselor/Therapist:**_____

Client Legal Name: _____ **Race:** _____
Last **First** **MI**

Address:_____
Street/Number **Town/City** **State** **Zip**

County of Residence: _____
Date of Birth: _____
SSN: _____**Male:** ____ **Female:** ____

Contact Telephone: Home: _____
Work: _____
Cell: _____
Previous Therapy Services and Date: _____
Previous DA: Y___ **N** ___ **(if Yes) Date:** _____
And Agency _____

Party Responsible for Paying: (Please Check One)
Grant/Insurance-Out of Network _____ **Company** _____
Policy/Group # _____ **Phone #** _____ **DOB** _____
County _____ **Cash** _____ **Debit** _____
Master Card _____ **Visa Card** _____ **Other Credit Card** _____

Reason For Referral: (Please check one) _____

Type of Service Requested:
1. Family Based _____
2. School Mental Health _____
3. Day Treatment _____
4. Group Therapy _____
5. FGDM _____
6. Counseling _____
7. Therapy _____
8. Daily Functioning Skills _____
9. Couple/Marriage _____
10. Individual _____
11. Intensive _____
12. Psychiatry _____
13. Other _____

(Initial and date all that apply)

Client Authorization for Third Party/ Other, Payment Claims:
I request that payment for services received from Unity Family Couple & Individual Therapy Services be made directly to Unity FCI Therapy Services and Bremer Bank Memo: (#363741182). This includes but not limited to the diagnosis, Release of information (General), Dates, Types of Services Needed for Myself/Dependents, and Family members for the purpose of processing this claim. My signature authorizes services, payments to be paid, and knowing it expires one year from the signed date. I understand that I may revoke this consent at any time except for extend that Unity FCI Therapy Services has disclosed data and services provided.

Signature: _____ **Date:** _____
Client or Legal Guardian's Full Legal Name

I, the Undersigned, and Confirm that: I give permission to release my records only to the absolute necessity of the (state)_____Department of Human Services (DHS) for outcome measures. I am willing to receive these services. I have received a copy of the Notice of Privacy Practices, Clients Rights and Responsibilities, and the use of telehealth service and policy.

Signature: _____**Date:** _____
Client or Legal Guardian's Full Legal Name

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