SGA Services Texas, LLC

Success * Growth * Achievement

P. O. Box 924705 ◆ Houston, Texas 77292

P-832-285-3911 ◆ F-832-553-2546

sgaservicestexas.com

CLIENT INFORMATION SHEET

DATE_____

Please Complete ALL information

Patient Demographics					
Patient Last Name:	First:			Chosen name if different:	
GENDER: ☐M ☐F ☐TG☐M-F ☐F-M ☐GNC	DOB:	Age:	Marital Status: ☐S ☐W ☐M ☐D ☐Separated How Long?		
Ethnic Origin: ☐Caucasian ☐African-American ☐Hispanic/Latino ☐Asian ☐American Indian ☐Other				Religion:	
Address:	Apt#:	City:	State/Zip:		
Cell Phone:	Home Phone:	Social Security #:	Driver's License and State:		
Employer Name:	Occupation:	Length of Emp.:	Employer Phone:		
Employer Address:	Suite#:	City:	State/Zip:		
Email:					
Emergency Contact:					
Emergency Contact:			Relationship:		
Address:	Apt#:	City:	State/Zip:		
Home Phone:	**Cell Phone**:	Work Phone:			

☐ I authorize consent to contact my EMERGENCY CONTACT in the event of an emergency (i.e. medical emergency, psychiatric emergency, etc. or if I am reporting ideas or plans to harm self or others). This authorization is valid while receiving services at SGA Services Texas, LLC.

_____ _____

Client Signature Date

SGA Services Texas, LLC

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PAYMENT PREFERENCE

☐ **PRIVATE PAYMENT** – I do not intend to use insurance to pay for my services at SGA Services Texas, LLC. I understand that that I am responsible for full payment for services at each visit.

☐ **OUT OF NETWORK INSURANCE** – I intend to use out of network insurance benefits to cover my services at SGA Services Texas, LLC. I understand that I am responsible for full payment for services at each visit and will receipt to seek reimbursement from my insurance company. I recognize that insurance companies vary in the percentages of reimbursement provided. I recognize that it is my responsibility to secure this pre-authorization.

☐ **IN NETWORK INSURANCE** – I intend to use my primary in-network insurance coverage benefits to cover my services at SGA Services Texas, LLC. I understand that it is my responsibility for the co-payment and/or co-insurance amount for my visit at the time of service. I authorize SGA Services Texas, LLC, to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company, if any, be made to SGA Services Texas, LLC and/or SONYA G. ADAMS, LCSW, LCDC, MAC, SAP, unless otherwise indicated on the claim. I authorize the release of any necessary information, including medical information for this and or any related claim, to my insurance carrier. In making this assignment I understand that I am financially responsible for any charges not paid under this policy. I further understand that SGA Services Texas, LLC will not file for secondary insurance on my behalf.

The following information applies to the insurance policy holder:

Policy Holder's Name (as it appears on card):
DOB:
Address:
Insurance Company Name:
Policy ID Number:
Group and/or Plan number:

_____

Client signature