COUNSELING AND DIAGNOSTIC
CENTER OF WOODFIELD, LTD.

-NO CHANGE-

DEMOGRAPHIC AND INSURANCE INFORMATION 2021

Date: _____/_____/_____

Client Name: ____

Date of Birth: _____/_____/_____

Responsible Party Name: ____

Relationship to Patient: ____

CDCW Provider: ____

I, the undersigned, attest that there have been no changes to my address or insurance information of record since my last session.

I, the undersigned, authorize the release of health information in communication with my insurance company for the purpose of billing for services rendered.

I, the undersigned, authorize the Counseling and Diagnostic Center of Woodfield, LTD. (CDCW) to bill my insurance company and be reimbursed directly for services rendered to me, and/or my dependent.

I, the undersigned, acknowledge that I will be held responsible for any and/all remaining balance, if any, due to (CDCW).

Signed
____/_____/_____
(Responsible Party)

Signed
____/_____/_____
(Client, if over the age of 12)