Christian Health Care Center
ESTABLISHED 1911

# CONSENT FOR TREATMENT
## CHCC OUTPATIENT THERAPY

**This is a treatment agreement, which Patient, Responsible Party, and Facility are identified below. Patient consents to treatment upon the provisions hereof and Patient/Responsible Party, and Facility hereby agree with each other as follows.**

Have you been a patient here before? ☐ Yes ☐ No
Who referred you to this program? _____
Are you receiving Home Health Care? ☐ Yes ☐ No
Have you had previous therapy? ☐ Yes ☐ No Where: _____

**Patient Information**
Name: _____
Social Security Number: _____ Date of Birth: _____
Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single Sex: ☐ Male ☐ Female
Spouse Name: _____
Address: _____
Home Phone: _____ Cell: _____
Email: _____@_____

**Emergency Contact Information – not living with patient**
Name: _____ Relation to patient: _____
Address: _____
Home Phone: _____ Cell: _____
Email: _____@_____

**Financial Responsible Party**
Name: _____ Relation to patient: _____
Address: _____
Home Phone: _____ Cell: _____
Email: _____@_____ Employer: _____

**Physician**
Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
Tax ID: _____ UPIN#: _____

**Primary Insurance Information – Insurance Plan Name:** _____
Subscriber Name: _____ Policy #: _____
Address: _____

**Secondary Insurance Information – Insurance Plan Name:** _____
Subscriber Name: _____ Policy #: _____
Address: _____

**Signature:** _____ Date: _____
Relationship: _____