## Sexual Assault Center Client Registration (Child/Adolescent)

PATIENT INFORMATION								
Legal Last Name Legal First Na			me	idle				
Client's Preferred Name	Former Name	E	Birth Date xx/xx/xxxx		Age	Sex	Gender:	
			1 1			□F		
						□M		
Race		1			Ethnic	ity	1	
□Alaskan Native □ Native American (or American Indian) □Asian □White □Pacific Islander □Hispanic/Latino □Non								
□Black (or African American) □Native Hawaiian □Decline to			specify 🚨			Hispanic./Latino		
						□ Decline to Specify		
Preferred contact for scheduling appointments Name:		Relationship to Client:			Phone Number:			
Preferred method of contact □Phone □Email Email:								
Client's Street Address/P.O.	City	State	ZIP Code	Social Se	curity	Client's I	Home Phone No.	
Вох				_	· .		( )	
County of Residence	Does anyone in the client's t	household	live or work in Davidson Co	untv?	-	Cell Pho	ne No	
□ Yes □No								
						(	)	
Please indicate the primary insurance:  □Aetna □BCBS □Cigna □Optum □UnitedHealthcare □Amerigroup □TennCare/Medicaid □United Healthcare Comm Plan □Other								
Primary Member ID:			_					
Member Name:			SSN: DC					
Who is the primary care physician?								
Family - Household income:								
□Less than \$10,890 □\$18,531- \$22,350 □\$29,991- \$33,810 □\$40,001- \$45,000 □\$60,001 −\$80,000 □\$10,891- \$14,710 □\$22,351- \$26,170 □\$33,811- \$37,630 □\$45,001- \$50,000 □\$80,001 -\$100,000								
	1- \$37,030 31- \$40,000							
□\$14,711-\$18,530 □\$26,171-\$29,990 □\$37,631-\$40,000 □\$50,001-\$60,000 □Over\$100,000								
Number of people living in household:								
How did you hear about us?	?							
☐ Website ☐ Crisis Line ☐ Hospital ☐ Doctor			□ Nurse □Other					
□ Family □ Friend □ Teacher □ School Counselor □ Community Health Fair □ Card/Pamphlet								
What school does the child attend?								
If Child is in DCS Custody Telephone:								
Guardian or case manager Name:								
IN CASE OF EMERGENCY								
Name		F	Relationship to SAC Client	H	ome Phone		Cell Phone	
				(	)		( )	
By signing this form, I authorize the	ne Sexual Assault Center to co	ontact the a	above listed person in the ca	ase of an e	mergency.		-	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the "Sexual Assault Center".								
I also authorize the Sexual Assault Center or insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance. The insurance co-pay will be determined from information obtained from the insurance company. If the actual co-pay								
amount differs from the amount listed, I will be responsible for the difference.								
I understand that payment is expected on the day of each appointment before each session begins, and that I will be charged according to the Attendance Policy for missed appointments not cancelled 24 hours in advance.								
X								
CLIENT/GUARDIAN SIGNATURE DATE								