ADMISSION BOOKKEEPING FORM

__ _ _/__ _ _/_ _ __ _____ __ _____ __ _____ _____ _ _____

Admission Date Client Name Client Log #

_____ __ ___ _____ ___ __ _____ _____ __ _____

Address City State Zip Code

___/___/___ ____-___-_____ (___) ____-_____ (___) ____-_____

Date of Birth Social Security Number Primary Phone Number Secondary/Message #

DSM IV Code _____ Primary Counselor __ _ _____ __ __ _____ _____

Payment Method _____ County _ _____ _ Private charges $ _____

Authorization Date Start : _ _ __ /___/____ End Date _ _ _ /___/____

_____

Change in Status

Effective this date ____/____/____ the following changes in status will occur _____ _ _ _____

_____ _____ _____
_____

Date Billing notified: _____/_____/ _____ _____

Effective this date_____ the following changes in status will occur _____ _____ __ _

_____
_____ _____

Date Billing notified: _____/_____/_____

_____

Effective this date ____/____/____ the following changes in status will occur _____ __

_____
_____ _____

Date Billing notified: _____/_____/_____