FHS
FINANCIAL HEALTH SERVICES, LLC

*Financial Health Services, LLC*

*Third party billing and related services.*

# FHS New Client Information Form

**Referring Office Information:**

Referring Office:

Coordinator Name:

Phone:

Email:

Date:

**Client Information**

Name:

Address:

Date of Birth:

SSN:

**Insurance Information**

Insurance Company Name:

Insurance Company Phone:

Policy Number/ID:

Has a claim already been initiated?

If yes, when?

Name/phone for Claim Specialist handling claim:

Any applicable power of attorney? Yes_____ No_____

**Services Needed**

Diagnosis/Services Needed:

Duration of Services:

Services Start Date:

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