A/R Management
REBEKAH WALKER LCSW
Nashville Child and Family Wellness Center
85 White Bridge Road, Ste 302
Nashville, TN 37205

CLIENT INFORMATION FOR A/R MANAGEMENT BILLING SERVICES

Client name: _____Gender___ Date of Birth _____
Age:___ Marital Status:___Single, ___Married ___Partnered ___Divorced ___Widowed

Home Address : _____

Email Address: _____

Home Phone: _____ Work #_____ Cell # _____
Best One To Reach you and Leave a Message: _____

Emergency Contact: _____Relationship:_____
Emergency Contact Number: _____

Referred By :_____/ #_____

Primary Care Physician: _____

I fully and freely consent to the release of any and all such patient information as is necessary for the processing of health care claims for reimbursement and for the process of accounts receivable for Rebekah Walker LCSW.

_____ _____
Signature of patient, parent or legal guardian Date

By signing below I acknowledge that I have read and understand the above information.

_____ _____
Signature of patent, parent or legal guardian Date