Client Name: _____ Client Date of Birth: _____

Client Information Form
Catalpa Health, Inc.

I authorize Catalpa Health to release to the entities below, information from my records relating to the identity, diagnosis, and treatment for the purposes specified:

A) Payment for services rendered. I recognize and accept responsibility for any balance or fee not covered by insurance. Payments in arrear may be submitted to a collection agency.
B) Parent/Guardian who is responsible for charges incurred by a minor child for the sole purpose of obtaining information & signatures mandated for insurance billing.
C) To my physician or the Catalpa Health's Medical Director for the purpose of obtaining prescriptions for treatment as required by law in order to received mandated health insurance benefits.
D) I hereby authorize payment of insurance benefits directly to Catalpa Health, 4635 W College Ave, Appleton, WI 54914
E) I acknowledge that a detailed Financial Policy is available upon request.
F) Non-discrimination Clause: Catalpa Health operates under the provisions of Title VI of the Civil Rights Act of 1964. Under this act, any provider of services receiving federal funds must comply with the intent of the act. This means there shall be no discrimination because of sex, race, color, or national origin. This Title also provides for strict complaint procedures. WPS 193-6-69.

_____ _____
Signature of Client *(if aged 14 or older)* Date

PARENT/LEGAL GUARDIAN:

_____ _____
Signature Parent/Legal Guardian Date

_____ _____ _____
Print Name Relationship to Client Date of Birth

_____
Full Address

_____
Phone Number