Request for Services

Date: Name of Person completing this request:

Who are you requesting this service for?
What is your relationship with this person?
Is this a San Mar TFC client?
Who is the San Mar case manager?
What is the contact number and email for the case manager?
Is this a Bester Community of Hope client?

Client Information

Name:	Phone:
Address:	
Email:	
School:	Grade:
Religion:	Marital Status:
Race:	Gender:
Insurance:	Phone:
Subscriber:	Date of Birth:
Subscriber Policy #:	Group #:
Subscriber SS#:	
Subscriber Employer:	
Client's Relationship to Subscriber:	
Client's Date of Birth: (if not Subscriber):	
Client's SS#: (if not Subscriber):	
Race:	
Name of Legal Guardian:	
Telephone Number:	
Address:	

How did you hear about the Center?

What is the reason for requesting services? Please share your immediate concerns, and previous/current medications.

Service type	Mark the ones that you wish to receive
Individual Therapy	
Couples Therapy	
Marriage counseling	
Groups	
Substance Use/dependency	
Grief & Loss	
Parenting issues	
Other Family therapy	
Psychiatric / Medication Management	

Are you in need of any special accommodations?

What is the best day and time that you would be available to participate in services?

To Be Completed by Billing Coordinator

INFORMATION TO BE OBTAINED FROM INSURANCE COMPANY:				
Effective Date of Coverage:				
Network Benefit:				
Deductible:			Deductible Currently Met:	
Visits Allowed:			Number of Visits on file:	
Authorization:				

Carepaths Information

Username:______________________________________

Password: ______________________________________