

CLIENT INFORMATION UPDATE

Providers are to complete this change of information form to ensure we have accurate and up-to-date records.

Client Name on Record: _____ **Today's Date:** _____

Effective Date of Change Listed Below: _____

*Please check information to be changed with this form and make necessary changes below.

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Client name | <input type="checkbox"/> Primary PDBTI provider | <input type="checkbox"/> Other |
| <input type="checkbox"/> Contact information | <input type="checkbox"/> Billing information | |

CONTACT INFO

Name change: _____

Street address: _____

City/State/Zip Code: _____

Telephone: (Home / Cell) _____ (Work) _____

Email: _____

Emergency contact update (name, relationship and telephone):

Primary contact method (circle one): (Home / Cell / Work / Email)

- New "Email/Text Message Consent Form" signed (*please attach*)

NEW PDBTI PRIMARY PROVIDER: _____

BILLING INFO

- New insurance information (please attach completed "Insurance Information Form" with copy of front/back of insurance card)

Insurance Name: _____ Circle one: (primary / secondary / tertiary)

- Check here if switching to self-pay and indicate any fee reductions if applicable:

IT= _____ FT= _____ MM= _____

GT= _____ PG= _____ NT= _____

Other= _____

- Change in financially responsible party (*attach* signed "Guarantor Policy" and ROI for financial information signed by client, if client is not a minor)

ADDITIONAL NOTES: