



2025 Client Application

Experience Freedom • Discover Hope

Office: 678-391-5950 Fax: 678-391-5969

Email: emily.woodfin-neal@hopequestgroup.org



RTC - Residential **HIOP** - High Intensity Outpatient **IOP** - Intensive Outpatient

| | | |
|---------|----------------|------|
| First | Middle | Last |
| SS# | Date of Birth | |
| Race | Marital Status | |
| Address | | |
| City | State | Zip |
| Phone | Email | |

Relevant Contact Information (Family, Medical Providers, Legal Contacts)

PLEASE ATTACH A LIST OF ADDITIONAL CONTACTS, IF NEEDED

| | | |
|---------|--------------|-----|
| Name | Relationship | |
| Address | | |
| City | State | Zip |
| Phone | Email | |

| | | |
|---------|--------------|-----|
| Name | Relationship | |
| Address | | |
| City | State | Zip |
| Phone | Email | |

| | | |
|---------|--------------|-----|
| Name | Relationship | |
| Address | | |
| City | State | Zip |
| Phone | Email | |

| | | |
|---------|--------------|-----|
| Name | Relationship | |
| Address | | |
| City | State | Zip |
| Phone | Email | |



Health Insurance Information

Insurance Company _____

Member Number _____

Group Number _____

Primary Policy Holder SELF

Name _____

Date of Birth _____

Address _____

Applicant Agreement

- Detox from all drugs and alcohol for a minimum of 72 hours prior to admission.
- Tuition must be paid in full at the time of admission.
- A 4% credit card processing fee will be charged for all credit card payments.
- I understand that if I am admitting under private pay status I cannot switch to insurance at a later date and that HopeQuest is not able to provide super bills for clients admitting under private pay status.

I have read and understand the above policies of The HopeQuest Ministry Group, Inc.

Print Name _____

Signature _____

Date _____



HOPEQUEST

PATIENT INFORMATION

| | | | | | |
|---------------|----------------------|------------|----------------------|--------|---|
| LAST NAME | <input type="text"/> | FIRST NAME | <input type="text"/> | M.I. | <input type="text"/> |
| DATE OF BIRTH | <input type="text"/> | LAST 4 SSN | <input type="text"/> | GENDER | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| ADDRESS | <input type="text"/> | | | APT # | <input type="text"/> |
| CITY | <input type="text"/> | STATE | <input type="text"/> | ZIP | <input type="text"/> |
| HOME PHONE | <input type="text"/> | CELL PHONE | <input type="text"/> | | |

INSURANCE

DO YOU HAVE ANY PRESCRIPTION INSURANCE? PRIVATE MEDICARE MEDICAID NO

| | | | | | |
|-----------------|----------------------|----------------|----------------------|-------|----------------------|
| INSURANCE BIN # | <input type="text"/> | INSURANCE ID # | <input type="text"/> | PCN # | <input type="text"/> |
| RX GROUP # | <input type="text"/> | INSURANCE NAME | <input type="text"/> | | |

PAYMENT INFORMATION

| | | | | | |
|--------------|-------------------------------|-------------------------------------|---|-----------------------------------|----------------------|
| CARD TYPE | <input type="checkbox"/> VISA | <input type="checkbox"/> MASTERCARD | <input type="checkbox"/> AMERICAN EXPRESS | <input type="checkbox"/> DISCOVER | |
| NAME ON CARD | <input type="text"/> | | BILLING ZIP | <input type="text"/> | |
| CARD NUMBER | <input type="text"/> | EXP. DATE | <input type="text"/> | CVV | <input type="text"/> |

KNOWN ALLERGIES & DRUG REACTIONS

- NO KNOWN ALLERGIES/DRUG REACTIONS
- ASPIRIN
- CEPHALOSPORINS (EX: KEFLEX, CECLOR)
- CODEINE
- ERYTHROMYCIN
- PENICILLINS
- SULFA DRUGS
- TETRACYCLINE
- XANTHINES (EX: THEOPHYLLINE)

Other Allergies or Known Drug Reactions:

Please list any prescription medications you are currently taking (not purchased at this store).

HEALTH CONDITIONS

- N/A
- ANGINA
- ANEMIA
- ARTHRITIS
- ASTHMA
- BLOOD CLOTS
- HIGH BLOOD PRESSURE
- CANCER
- DIABETES
- HEART DISEASE
- KIDNEY DISEASE
- LIVER DISEASE
- LUNG DISEASE
- PARKINSON'S DISEASE
- THYROID
- ULCERS

Other Health Conditions:

Please list any non-prescription/OTC medications you are currently taking.

PATIENT SIGNATURE

The pharmacy has requested the above information for their records. The above information will be kept confidential. You authorize the pharmacy to bill your insurance and payment information listed above for goods and services received from the pharmacy. Since health information may change periodically, please notify us of any changes in medication you take (prescription and non-prescription), allergies, drug reactions, and/or health conditions.

PATIENT NAME (PRINTED)

PATIENT SIGNATURE _____

DATE



Woodstock Health Mart Pharmacy

8612 Main Street

Woodstock, GA 30188

Phone (770) 926-6478 • Fax (770) 591-7557

I, , authorize Woodstock Pharmacy to repackage my medications in accordance with the Rules and Regulations of the State of Georgia, Rule 480-9-.04 Redispensing by a Different Pharmacy.

PATIENT SIGNATURE _____ DATE

OR

CAREGIVER SIGNATURE _____ DATE