



PO Box 624, Tiffin, OH 44883
419.937.2540

Client Application Form

Please complete this form, **sign and date it**. Return it along with your **completed, signed and dated** Physician Authorization Form and copy of your driver's license to F.A.C.T. at the above address.

Name: _____
Address: _____ **Sex:** M or F
City, State, Zip: _____ **Date of Birth:** _____
Previous address if less than 2 years: _____

Telephone: _____ **E-Mail:** _____
Cellphone: _____

Please provide a copy of your driver's license or state issued ID. Proof of residency may be required: (utility bill or bank statement)

Authorized Contact Person: _____
Address: _____
City, State, Zip: _____ **Telephone:** _____

Physician: _____
Address: _____
City, State, Zip: _____ **Telephone:** _____

Diagnosis: _____

Informed Consent

All information on this form is strictly confidential and will be treated as such by F.A.C.T. I authorize F.A.C.T. to discuss my care and treatment related to payment of claims to verify such claims submitted are cancer related. I have reviewed and understand The Services and Rehabilitation Policy of F.A.C.T. of which a copy has been provided to me.

Signature: _____ **Date:** _____

Serving Seneca County, Ohio Cancer Patients

Due to board policy, we cannot make reimbursement for any receipt or transportation that is 6 months or older.