Patient & Insurance Information Form

Patient's Name:______________________________
Patient's Address:____________________________
City:______________________________
State:_________________ ZIP Code:___________
Patient's Date of Birth:_______/_______/________
Sex: 9Male 9Female
Patient's Phone Number: (___) ______-__________
Patient's Relationship to Insured:
9Self 9Spouse 9Child 9Other
Patient's Status: 9Single 9Married 9Other
]
9Employed 9Full Time Student 9Part Time Student

Is Patient's Condition Related To:
]
Employment? 9Yes 9No
Auto Accident? 9Yes 9No State______
]
Other Accident? 9Yes 9No

]

#_____________________]

Insured's ID Number:
Insured's Name:
Insured's Address:
City:
State:__________________ ZIP Code:
Insured's Date of Birth:_______/_______/
Sex: 9Male 9Female
Insured's Phone Number: (___)______-
Insured's Policy Group or FECA Number
[

Insured's Employers Name or School Name

[

Insurance Plan Name or Program Name
[

Is There Another Health Benefit Plan? Please List

[

[**Authorization/Certification**

CONSENT, ASSIGNMENT AND RELEASE

I, the undersigned give my consent for treatment for the patient listed above. I, the undersigned certify that I (or my dependant) have insurance coverage with the above mentioned insurance company and assign directly to all insurance benefits, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that all co-payments and deductibles are do at the time of service. I understand that the therapist will bill my insurance and that if payment for services is not received within 45 days of billing said company, that the therapist at his or her discretion can rescind the assignment of benefits and bill me directly for any and all service related costs. I further understand that I need to give a 48 hour notice if I need to cancel a scheduled session. If I fail to attend a scheduled session and have not given notice as described above, I will be expected to pay the full normal rate fee of $125.00 for that session unless the therapist and I both agree I was unable to attend because of circumstances beyond my control. I also understand that if my account gets placed into collections I will also be responsible for all charges associated with collection services as well as attorney fees and court costs. I hereby authorize the therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client and or Responsible Party : ____Date:

Telephone Contact Permission Form

Occasionally, we may find that we need to contact you regarding your appointments or your account. In an effort to protect your privacy, please fill out the following questionnaire on what would be the best way to contact you personally.

May we contact you regarding your appointments or your account? ____Yes ____No

What number do you prefer to be contacted at? May we leave a voice message on that number?

Home # _________________________ ____Yes ____No ____Yes ____No

Cell# _________________________ ____Yes ____No ____Yes ____No

Work# _____________________ ___ ____Yes ____No ____Yes ____No

If you are not at home, may we leave a message with someone at your residence? ____Yes ____No

Person to contact in case of emergency:

Name___________________________ Phone:_____________________ Relationship__________

Signature______________________________ Date: _________________