Patient Information

Last Name: ____________________________ First Name: ____________________________ Middle Initial: _________

Date of Birth: _______/_______/_____Marital Status: _____Single____Married _____ Divorced_____ Widowed

Patient's Address: ____

City: ________________________ State: _______ Zip Code: __________

Cell Phone: _____________________ Home Phone: _____________________ Work Phone: ___________________

Patient Employer: __________________________________

Insurance Subscriber's Information

Last Name: ____________________________ First Name: ____________________________ Middle Initial: _____

Subscriber's Relationship to Patient: __________________________Subscriber's DOB: _______/_______/_______

Subscriber's Address: ____

City: __________________________ State: _______ Zip Code: ____________

Cell Phone: _____________________ Home Phone: _____________________ Work Phone: _____________________

Subscriber's Employer: ___________________________

INSURANCE COMPANY: __________________SUBSCRIBER ID:__________________________ GROUP # ______________

HOUSEHOLD MEMBERS (Including the Patient)

Name	Age	Occupation/Employer
____	_________	___________________________
____	_________	___________________________
____	_________	___________________________
____	_________	___________________________

Emergency Contact: _________________________ Phone: _______________________

I give permission for my therapist to collect money from and communicate directly with my insurance company about me. I also understand that I am financially responsible for all charges made during the course of treatment and agree to pay as treatment progresses. Should I default on payment, I understand that my balance is subject to collections charges.

Signature: _______________________________________ Date: _______________________