

OFFICE USE DX: _____

PATIENT INFORMATION

First Name	Middle	Last	Birth Date	Age	Sex
Street Address			City	State	Zip
Home Phone	Work Phone	Cell Phone	Social Security #		
Employer	Employer Address	Email Address			

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name	Middle	Last	Birth Date	Age	Sex
Street Address			City	State	Zip
Home Phone	Work Phone	Employer	Social Security #		

PRIMARY INSURANCE

Name of Insurance Company	Co-payment	Policy ID No.	Group #
Street Address		City	State Zip
Name of Policy Holder		Date of Birth	Relationship to Insured
Employer Name/Address			

SECONDARY INSURANCE COMPANY

Name of Insurance Company	Policy ID No.	Group #	
Street Address		City	State Zip
Name of Policy Holder		Date of Birth	Relationship to Insured
Employer Name/Address			

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to _____.

I also authorize _____ to release to my insurance company any and all information necessary for the processing of insurance claims.

I understand there is a 24 Hour cancellation policy which requires that I cancel my appointment 24 hours in advance to avoid the full charge of the session.

Signature

Date