THERAPIST NAME: _____ APPT. DATE: _____
PCP/REFERRING PRACTIONER: _____

PATIENT'S LEGAL NAME: _____
PATIENT'S CHOSEN NAME: _____DATE OF BIRTH: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
SS#: _____ EMPLOYER: _____
PREFERRED PHONE: _____ EMAIL: _____
LEGALLY REGISTERED SEX: M☐ F☐ PRONOUNS: _____
GENDER IDENTITY: CISGEN.☐ BIGEN.☐ AGEN.☐ GENDERFLUID☐ TRANSGEN.☐ NOT LISTED __
RELATIONSHIP STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ NOT LISTED _____
RESPONSIBLE PARTY: _____ SS#: _____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE: _____ WORK PHONE: _____

INSURANCE #1: _____
POLICY/ENROLLEE #: _____ GROUP #: _____
POLICY HOLDER: _____ SS#: _____
INSURED DATE OF BIRTH: _____ EMPLOYER: _____

INSURANCE #2: _____
POLICY/ENROLLEE #: _____ GROUP #: _____
POLICY HOLDER: _____ SS#: _____
INSURED DATE OF BIRTH: _____ EMPLOYER: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)
NAME: _____ RELATIONSHIP: _____
PRIMARY PHONE: _____ALT. PHONE: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)
In order to submit a claim for payment to us for services covered under your policy we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize therapist's billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to therapist. If I have Medicare insurance, I authorize the therapist to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the therapist by written request.

SIGNATURE: _____ DATE: _____
WITNESS: _____ DATE: _____