Patient Information

Name________________________________ Age_______ Date of Birth_____________________

Address____ City_________________ State________

Zip_____________ Email__________________________________ Soc Sec # xxx-xx-__________

Cell Phone______________________ Home______________________ Work_________________

Employer____

Address____

Emergency Contact____ Phone_________________

Insurance Company____

Subscriber ID #___________________________________ Group #_________________________

Subscriber Name_____________________________________ Sub Birthdate________________

Authorization Phone Number (on back of card)______________________________________

I was referred by:____

__friend or family __physician __google __website __ other professional________________

Fee:_____________________________ ICD-9 Dx:_______________________

I agree to begin the therapy process and agree that I will be responsible for fees for services not covered or paid by my insurance company. I understand that my personal information will remain confidential according to HIPAA requirements and will only be released with my written consent or as required by law.

____ __________________________________

Patient Signature Date Witness Date