THERAPIST: DATE:

PATIENT INFORMATION

Last name: _____

First name: _____

Middle name: _____

Preferred name: _____

Street address: _____

_____

City: _____

State: _____ Zip Code: _____

Home phone: _____

Work phone: _____

Mobile phone: _____

Social Security no.: _____

Sex assigned at birth: _____

Gender identity: _____

Preferred pronouns: _____

Race: _____

Ethnicity: _____

Language (primary): _____

Marital status: _____

Home email: _____

May we contact you through email? _____

Birth date: _____

Today's date: _____

Primary insurance: _____

Policy number: _____

Group number: _____

Policy holder: _____

Policy holder's DOB: _____

Policy holder's phone: _____

Co-pay: _____

Secondary insurance: _____

Policy number: _____

Group number: _____

Policy holder: _____

Policy holder's DOB: _____

Policy holder's phone: _____

Co-pay: _____

ICD code (to be filled by therapist):

_____

_____

All appointments will be billed unless cancelled no less than 24 hours prior or excused by the therapist.

I grant permission to release information requested by my insurance carrier for the purpose of reimbursement. I also authorize insurance payment to be paid directly to my therapist.

_____

Signature of patient or legal guardian