PATIENT INFORMATION

Last Name____ First _______________________Middle _____________

_____Male _____ Female Date of Birth____

Address ____City________________________St____ Zip_________

Home Phone (___)___________ Cell Phone (___)___________ Email ____________________________________

Employer____________________________________ Address ____

City ______________________________St_______ Zip_________ Phone_______________ Ext#_______________

RESPONSIBLE PARTY INFORMATION

(If different than Patient)

Responsible Party Last Name________________________________ First___________________________ M.I.____

_____Male _____ Female Date of Birth____

Address ____City____________________St_____ Zip_________

Home Phone: (___)____________ Cell Phone: (___)___________ Email: _______________________________________

Employer _____________________ Address ____

City ______________________________St_______ Zip_____________ Phone___________________ Ext#_______

INSURANCE INFORMATION

Insurance Co.______________________ID#___________________________________ Group #___________________

Insurance Phone#__________________Subscriber's name________________________Date of Birth__________

SECONDARY INSURANCE INFORMATION

Insurance Co.______________________ID#___________________________________ Group #___________________

Insurance Phone#__________________Subscriber's name________________________Date of Birth__________

PERSONAL INJURY INFORMATION

Insurance ____ Insurance Phone# ______________________________

Policy# ________________________________ Claim #____

Date of Injury ____________________ Adjuster____ EXT.___________

Has this injury been reported to your Insurance? _____ yes _____ no

I agree, if I do not give 24 hours notice of cancelling my appointment I will be billed $50.00 __________. (initial)
By initialing here _____.(initial) I acknowledge NOTICE OF PRIVACY PRACTICES are available to me on the office website and a printed copy will be supplied to be upon request.

By signing this intake, I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment if coverage is not available. I also authorize the release of any medical or other information to Puget Sound Medical Billing, necessary to process insurance claims related to treatment. I request all insurance payments be sent directly to this Provider for all services rendered.

____ ___________________________________

Signature (Parent or Guardian, if applicable) Date