PATIENT INFORMATION FORM

DATE: ______________________ THERAPIST'S NAME: _______________________________

NAME: ____ BIRTHDATE: _____/_____/______

ADDRESS: ____

PHONE: ________________________ Use This Phone for Calls and Messages _________________

RESPONSIBLE PARTY (if other than client) Spouse/Parent/Guardian _________________________

Name____ BIRTHDATE: _____/_____/_______

Address: ____

PHONE: ________________________ Use This Phone for Calls and Messages _________________

Employer: ____

INSURANCE/EAP INFORMATION

PRIMARY INSURANCE: __________________________________ PHONE NO. __________________

ADDRESS: ____

POLICY/ID NUMBER: ___________________________________ Group/Plan #: _________________

SECONDARY INSURANCE: __________________________________ PHONE NO. _______________

ADDRESS: ____

POLICYHOLDER: ____________________________________ EMPLOYER: _______________________

POLICY/ID NUMBER: ___________________________________ Group/Plan #: _________________

Cancellation Policy: If you need to cancel or reschedule an appointment, please give 24 business hour's notice, otherwise you will be billed a late cancellation fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.