PATIENT INTAKE FORM

Demographic Information

Name: ____ **Date of Birth**: ________________

Address: ____ **Apt No.**: _______________

City: _____________________ **State**: ___________________ **Zip**: _________________

Phone: Home: ____________________________ Cell: _____________________________

Email: ____ **Sex**: _________________

Insurance Information – (NOTE: INSURANCE CARD MUST BE PRESENTED)

Primary Insurance Provider: ____

Policy Owner: _________________________ **Relationship to Patient**: __________________

Date of Birth: ___________________ **Policy Number**: ______________________________

Secondary Insurance Provider: _______________________ **Policy #**: _________________

Please briefly describe the issue you are seeking care for:

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I hereby assign to you, my healthcare provider, where appropriate and approved to you and your carrier, all medical benefits to which I am entitled.

1. **I agree to pay all and any deductible, co-payments or co-insurance according to my insurance policy at each visit. Co-payments will not be billed. They must be paid at the time of visit. A $5.00 fee will be charged.**
2. I hereby authorize said assignee to release all information to secure payment.
3. I understand that I am financially responsible for all charges whether or not paid by said insurance and that payments are due at the tim eservices are rendered.
4. **I understand there will be a $50 fee for all appointments missed or cancelled without proper notice (72 hours for therapy, and 24 hours for MD).**
5. I understand that no prescription will be called in from this office. It is my responsibility to discuss my medication with my doctor and make sure I will have enough to last until my next visit.

I CERTIFY THAT I HAVE READ FULLY UNDERSTAND AND AGREE TO THESE TERMS

Signature: ____ **Date**: ____________________