

PATIENT INFORMATION

Patient Name: _____ M / F _____

Home PH#: (____) _____ - _____ Cell PH#: (____) _____ - _____* D.O.B. _____

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____

SS#: _____ Age: _____ Email Address: _____

Employer/School: _____

Occupation: _____ PH: (____) _____ - _____

*I give HSWC permission to call or text message me about my appointment or other matters on my cell phone.

EMERGENCY INFORMATION

Contact: _____ Relationship: _____

Phone #'s: (____) _____ - _____ Cell PH#: (____) _____ - _____

PRIMARY INSURANCE

Ins. Company: _____

Member ID#: _____ Group #: _____

If different from the patient...

Insured Name: _____ D.O.B: _____

Employer: _____ PH#: (____) _____ - _____

SECONDARY INSURANCE

Ins. Company: _____

Member ID#: _____ Group #: _____

If different from the patient...

Insured Name: _____ D.O.B: _____

Employer: _____ PH#: (____) _____ - _____

I, the undersigned, certify that I (or my dependent) have coverage with _____ and assign directly to Karen Pryor, PhD, PT, all insurance benefits, if any, and otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the above party to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/ Parent/ Guardian

Date