AVONDALE THERAPY
PATIENT INFORMATION FORM

(Please print)

Today's Date _____

Patient's Full Name _____ SS # _____

Home Address _____ City _____ Sate ____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email address _____ Preferred contact method email phone

Sex: M F Age _____ Date of Birth _____ Marital Status _____

Emergency Contact _____ Phone _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name on insurance card _____ Relationship to patient _____
Employer _____

Home address (if different from above) _____
(include city, state, and zip code)

Insured's SS # _____ Date of birth _____

Spouse Full Name _____ Phone _____

Primary Insurance _____ I.D. # _____

Secondary Insurance _____ I.D. # _____

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions
2. I authorize the release of information to my insurance company(s)
3. I understand that I am responsible for the full amount of my bill for services provided
4. I understand payment is due when services are rendered

Signature _____ Date _____

Guardian: as parent or legal guardian of _____, I authorize his/her treatment.
Signature _____ Date _____

_____ (Initials) I understand phone calls after hours (5:00pm) and on weekends will have a charge of $25.00 per half hour if the length of the call exceeds five minutes. There is also a $70.00 no show fee when you do not cancel 24 hours before an appointment

_____ (Initials) Any legal/court related matters including creating and sending documents and interviews/testimonies will be billed at $25.00 per 15 minute increment. Insurance does not cover these billings; I understand I will be 100% financially responsible for these charges.