PATIENT INFORMATION

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Patient's Last name: First:		Middle:	Marital status:		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date: [Birthday]	Age:	Sex: ☐ M ☐ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Preferred contact method:		
Referred by:					
Current Medications:					

INSURANCE INFORMATION					
Occupation:	Employer:	Employer address: (optional)	Employer phone no:(optional)		
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: [Birthday]	Group no.:	Policy no.:	
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize payment to Mary Lou Tabers L.M.F.T of any insurance or health plan benefits otherwise payable to me, but not to exceed regular charges for services. I agree to assume financial responsibility for any changes not covered.

I hereby authorize examination and other medical services deemed necessary. I hereby authorize the release of any information required by my insurance carrier for services furnished me in order to process claims on my behalf.

I READ THE ABOVE CAREFULLY, UNDERSTAND ALL OF ITS CONTENTS AND SIGN MY NAME HEREUNDER AS AUTHORIZATION

Patient/Guardian signature

Date