
New Patient Information

Name _____ Today's Date _____
Street Address _____ Apt. _____
City _____ State _____ Zip _____
Preferred Phone _____ Email _____
Birth Date (include year) _____ Age _____ Gender _____
Occupation _____ Employer _____
Referred by _____

Emergency Contact: Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

I understand the cancellation policy.

Signature: _____ Date: ____/____/____