CHILDREN'S PROGRAM ADULT INFORMATION FORM

BY PROVIDING THIS INFORMATION, I AUTHORIZE YOU TO GIVE REASONABLE AND PROPER CARE BY TODAY'S STANDARDS

Patient: _____ **Date:** _____
Full Legal Name Preferred Name

Birthdate: _____ **Gender Identity** _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Cell Phone: _____ **Other Phone:** _____

Billing Address: _____
(If different) (Street/P.O. Box) (City) (State) (Zip)

E-mail Address: _____
(By furnishing my email address, I consent to the use of email to communicate.)

Patient's Primary Care Physician: _____ **Referred:** ☐ **Yes** ☐ **No**

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Primary Insurance Company: _____
(Name) (Billing Address)

Subscriber's Name: _____ **Subscriber's DOB:** _____ **Relationship to Client** _____

Identification #: _____ **Group #**: _____

All patients must maintain a credit card on file. The amount for which you are responsible will be processed following your visit. Balances remaining after 90 days will be charged to avoid further billing or collection fees. Billing staff will attempt to contact the financially responsible party prior to authorizing payment of overdue charges.

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Card# _____ **Zip Code** _____ **Exp** _____ **Security Code** _____

Signature of Financially Responsible Party **Relationship to Patient** **Date**

Please Print Name of Responsible Party **Statement Email Address**

PLEASE INFORM US IF YOU HAVE SECONDARY INSURANCE

This form MUST be filled out COMPLETELY and received prior to your first appointment. A health insurance card MUST be presented at the first appointment. Federal Law requires verification of the identity/address of the patient, patient, person responsible for fees, and insurance subscriber. Please be prepared to provide this documentation with a PHOTO ID with an address or alternate documentation of address at check-in.