# Client Information Form

| | | | |
|---|---|---|---|
| Patient Name: Last | First | Middle | Social Security #: |

Reason for Therapy:

OT referrals: Has the patient had any OT in the past 366 days? ☐ Yes ☐ No
Where?

| | |
|---|---|
| Street Address (Include unit # if applicable): | Home Phone: |
| City, State, and Zip Code: | Cell Phone: |

| | | |
|---|---|---|
| Gender (check) ☐ *Female* ☐ *Male* | Date of Birth: | Age: |

| | |
|---|---|
| Physician Name: | Physician Phone #: |
| Physician Practice Name: | |

**I hereby authorize you to release medical information about me to my physician ☐ Yes ☐ No**

**Please complete the appropriate information below**

| | | |
|---|---|---|
| I am the Patient/Parent/Guardian | Employer | Business Phone |
| Spouse (if applicable) | Employer | Business Phone |

Best E-mail for Notifications and Billing (☐ Mother ☐ Father ☐ Spouse):

Best Means to Reach You: ☐ *Home Phone* ☐ *Cell Phone* ☐ *Text* ☐ *Email*

How did you hear about ABG Therapy? (check)
☐ *Physician* ☐ *Friend* ☐ *Family Member* ☐ *Insurance* ☐ *Radio* ☐ *Website* ☐ *Social Media*

Emergency Contact Name: Phone:

Parents are (check): ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Not Applicable*

Name & Telephone number of parent and/or legal guardian with right to make medical decisions:



*This information is confidential.*

**INSURANCE INFORMATION** – Please show your card to the front desk administrator or your therapist. If you are unable to provide this information, you will be responsible for filing claims to your insurance company*

| **Primary Insurance Name:** | Group # | Policy # | Phone |
|---|---|---|---|
| Claims Address *(See back of insurance card)* | City | State | Zip Code |
| Policy holder name: | | Date of birth | Social Security Number |
| **Secondary Insurance:** | Group # | Policy # | Phone |
| Claims Address *(See back of insurance card)* | City | State | Zip Code |
| Policy holder name: | | Date of birth | Social Security Number |

_____ (Initial) **I AGREE TO PAY** ABG Therapy & Wellness Center LLC for the services provided. I am responsible for all charges regardless of insurance coverage.

***For in-network plans***, as a courtesy, ABG Therapy & Wellness Center LLC will submit my claims to my health insurance plan(s). However, I will be financially responsible for all charges not covered by my health insurance plan and deductibles, co-pays, and co-insurance are to be paid at the time of service.

**For *out-of-network plans***, I understand that I will be responsible for all charges at the time of my appointment and I will be given a Superbill that I can submit to my insurance for reimbursement directly to me.

I also understand that it is my responsibility to contact my insurance company to verify therapy benefits & to confirm that the required referral or authorization is in place prior to receiving therapy services.

If my insurance denies coverage as "not medically necessary" I will be responsible for the denied charges. I also understand that if, at any time, my insurance policy or company changes, I will be solely liable for any and all charges insurance denies that are a result of the change.

**Treatment Authorization** – I hereby authorize ABG Therapy & Wellness Center LLC, or their designee(s), to treat my or the patient's condition as they deem appropriate. Records Release on File with Clinic

**Assignment of Benefits** – I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to ABG Therapy & Wellness Center LLC for any services rendered to me by or on behalf of ABG Therapy & Wellness Center LLC.

**I have received a copy of the ABG Therapy & Wellness Center LLC Privacy Policy.**

**Client name: _____**

**Name of responsible party: _____**

**Signature of responsible party: _____**

**Date : _____**