Life Care Wellness

CLIENT DEMOGRAPHIC INFORMATION				
Name:			Date of Birth:	
Address:	City		State	Zip
Phone (H):	Phone (W)	Phone (C)		
Email:				
Marital Status:	Student - Status Please Circle: P/T F/T N/A			
Spouse Name:				
Emergency Contact:				
Address:	Phone:			
Family Physician:	Phone:			
Psychiatrist:	Phone:			
How did you hear about us?	❑ Referral	❑ Life Care Website	❑ Google	❑ Other
(check all that apply)	*Who?*	❑ PsychologyToday	❑ Bing	
Keywords or phrase you used in your search:				

Primary Insurance Policy			
Insurance Company		Insured's Name	
Address		Address	
City State, Zip		City, State, Zip	
Phone		Phone	
Policy ID		Employer	
Group		Birth Date	
Self ❑	Spouse ❑	Child ❑	Other *Who?*

Secondary Insurance Policy			
Insurance Company		Insured's Name	
Address		Address	
City, State Zip		City, State, Zip	
Phone		Phone	
Policy ID		Employer	
Group		Birth Date	
Self ❑	Spouse ❑	Child ❑	Other *Who?*

1. I agree to pay in full for services rendered at the time of each session unless otherwise agreed. I understand I am responsible for payment regardless of whether I am reimbursed for these services by my insurance company.
2. I authorize Life Care Wellness to release any medical information or service information necessary to process the claim for services rendered.
3. It is my intent that a copy of this authorization carries the same force and effect as the original.
4. I understand that if I fail to provide at least 24 hours advance notice of cancellation of a session that I am responsible for payment of the full fee for the missed appointment.
5. I authorize my insurance company to assign benefits to Life Care Wellness

Signature of Responsible Party	**Date**
Driver's License Number:	
For Office Purposes	Therapist Name: DSM V: