Client Name:

Last First MI

Mailing Address:

City State Zip Code

Home Phone: Work Phone:Cell

Birth date:SSN:  Male Female Transgender

Marital Status: Single Married Divorced Separated Widowed

Email Address:  Employer:Occupation:

**Client/Guardian**:

**(If Patient is a Minor)** Last First MI

Referring Provider: (If Applicable) Medical Provider

## *INSURANCE INFORMATION MUST BE COMPLETED IN FULL: Please be sure we take a copy of your ID cards*

Primary Insurance:  Address:

Phone #: **Group #       ID #**

Insured’s Name:  Relation to Patient:  **DOB**

Insured’s Employer: (If applicable to plan)  Phone #

Secondary Insurance:  Address:

Phone #: **Group #       ID #**

Insured’s Name:  Relation to Patient:  **DOB**

Insured’s Employer: (If applicable to plan)  Phone #

I understand all payments for treatment received are my responsibility. I hereby acknowledge the release of any information to my insurance company that is required to process a claim on my behalf.

I hereby authorize my insurance company to remit payment for any medical benefits due, directly to Uncommon Therapy/Uncommon Opportunities. This authorization shall expire in one year or upon my written notice.

I also acknowledge that I have received or read a copy of Uncommon Therapy’sNotice of Privacy Practices, and I have been given an opportunity to ask any questions regarding these practices. I understand that I have a right to a copy of this Notice upon my request.

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_