Thank you for selecting Daring Minds Therapy

We will strive to provide you with the best possible care. To help us meet your entire healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask & we will be happy to help.

Date ________________________

Patient/Guarantor Information

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name ____ DOB_____/______/_______

Home Phone__________________________________ Cell Phone ___________________________________

Physical Address ____ City _________________ St ______ Zip

Mailing Address (if different from above) ______________________ City _________________ St ______ Zip ______

Soc Sec #: _______/_______/_________

Patient/Guarantor Employer ____Work Ph _________________

Employer Address _____________________________________ City_____________ St _____ Zip _________

Guarantor Personal Email Address ____

SPOUSE, PARENT, OTHER-Relationship to patient____

Name ____ DOB___/____/______

Home Phone__________________________________ Cell Phone ___________________________________

Address ____ City _________________ St ______ Zip _________

Soc Sec #: ______/______/________

Employer ____Work Ph _________________

Employer Address _____________________________________ City_____________ St _____ Zip _________

Personal Email Address ____

If Patient is a Student, Name of School/College ____

City __________________ State ________

Person to Contact in Case of Emergency ____

Phone ________________________ Address _________________________________

Non Family Member Contact ____

Phone ________________________ Address _________________________________

Who is responsible for the patient's medical care? ____

Whom May We Thank for Referring You? ____

- over -

Insurance Information

Do you have Medicaid? Yes or No (obtain managed care card if applicable as well as Medicaid card)

Name of Insured ____ Relationship to Patient ________________

DOB _________________ Soc Sec # _______/_______/_________ Employer _________________________

Insurance Company ____

Group#_____________________ Group Name ____________________ Policy ID# _____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, Complete the following:

Name of Insured ____ Relationship to Patient ________________

DOB _________________ Soc Sec # _______/_______/_________ Employer _________________________

Insurance Company ____

Group#_____________________ Group Name ____________________ Policy ID# _____________________

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief.
I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice.
I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers. I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications.

X ____

Signature of Patient/Guarantor